

SERFF Tracking Number: HARL-125556846 State: Arkansas
Filing Company: Hartford Life and Accident Insurance Company State Tracking Number: 38462
Company Tracking Number: GBD 2008 GRIP
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: GCF_AR_HLA_2008_GRIP_GBD-1570 A.1
Project Name/Number: /

Filing at a Glance

Company: Hartford Life and Accident Insurance Company

Product Name: SERFF Tr Num: HARL-125556846 State: ArkansasLH

GCF_AR_HLA_2008_GRIP_GBD-1570 A.1

TOI: H21 Health - Other

SERFF Status: Closed

State Tr Num: 38462

Sub-TOI: H21.000 Health - Other

Co Tr Num: GBD 2008 GRIP

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Yolanda Topps,

Disposition Date: 03/24/2008

Christopher Berning

Date Submitted: 03/19/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 03/07/2008

Requested Filing Mode:

Domicile Status Comments: Domicile state of CT.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Trust

Filing Status Changed: 03/24/2008

State Status Changed: 03/24/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We submit the subject forms for your review and approval, for general use in your state. These forms are new, and not intended to replace any previously approved forms.

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Company and Contact

Filing Contact Information

Christopher Berning, christopher.berning@hartfordlife.com
 200 Hopmeadow St. (860) 843-3641 [Phone]
 Simsbury, CT 06089

Filing Company Information

Hartford Life and Accident Insurance Company CoCode: 70815 State of Domicile: Connecticut
 200 Hopmeadow Street Group Code: 91 Company Type: Life
 Simsbury, CT 06089 Group Name: State ID Number:
 (860) 547-5000 ext. [Phone] FEIN Number: 06-0838648

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50 per filing.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Hartford Life and Accident Insurance Company	\$50.00	03/19/2008	18795476

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/24/2008	03/24/2008

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Disposition

Disposition Date: 03/24/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	3-19-08 Filing Letter	Approved-Closed	Yes
Supporting Document	3-19-08 NAIC Transmittal	Approved-Closed	Yes
Form	Policy of Incorporation	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Exception Provision	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Policy Rider	Approved-Closed	Yes
Form	Certificate Rider	Approved-Closed	Yes
Form	Form List	Approved-Closed	Yes

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 Product Name: GCF_AR_HLA_2008_GRIP_GBD-1570 A.1
 Project Name/Number: /

Form Schedule

Lead Form Number: GBD-1570 A.1

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GBD-1570 A.1	Policy/Cont	Policy of Fraternal Incorporation Certificate	Initial		52	3-19-08 Policy of Inc, GBD-1570 (HLA).pdf
Approved-Closed	GBD-1570 CRT A.1	Certificate	Certificate	Initial		53	3-19-08 Certificate, GBD-1570 CRT (HLA).pdf
Approved-Closed	GBD-1570 SCHED	Schedule Pages	Schedule of Benefits	Initial		0	3-19-08 Schedule, GBD-1570 SCHED (HLA).pdf
Approved-Closed	GBD-1575	Other	Exception Provision	Initial		0	3-19-08 St Mandates and Excptns Pg for Cert, GBD-1575 (HLA).pdf
Approved-Closed	GBD-1580	Application/ Enrollment Form	Application	Initial		0	3-19-08 Application, GBD-1580 (HLA).pdf
Approved-Closed	GBD-1595	Policy/Cont	Policy Rider Fraternal Certificate: Amendment, Insert Page, Endorseme	Initial		0	3-19-08 Policy Rider, GBD-1595 (HLA).pdf

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 Product Name: GCF_AR_HLA_2008_GRIP_GBD-1570 A.1
 Project Name/Number: /
 nt or Rider

Approved- GBD-1598	Policy/Cont Certificate Rider	Initial	0	3-19-08
Closed	ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider			Certificate Rider, GBD-1598 (HLA).pdf
Approved- Form List	Other Form List	Initial	0	3-19-08
Closed				Forms List (HLA).pdf



HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

200 Hopmeadow Street, Simsbury, Connecticut 06070

(A stock insurance company, herein called The Company)

will pay benefits according to the terms and conditions of this Policy.

Signed for The Company:

[

Richard G. Costello, *Secretary*

Thomas M. Marra, *President*

]

THE HARTFORD GROUP RETIREE INSURANCE PLAN ®

This is a Supplemental Policy only.

Policyholder Name: [ABC Employer]

Policy Number: [AGP-XXXX]

Policyholder Address: [Any Street, Any Town/State Zip]

Policy Effective Date: [April 1, 2008]

Policy Renewal Date: [April 1, 2009] and each [April 1st] thereafter unless mutually agreed upon between the Policyholder and Us.

Table of Contents

Schedule

[Participating Entities]

Contract Provisions

Incorporation Provision

[Accepted by

Countersigned by

Policyholder

Licensed Resident Agent]

SCHEDULE – PREMIUMS

Individual Premiums: Premiums for each Covered Person are stated below.

Premiums are based on:

- a) [Age on the effective date of a Covered Person’s coverage and on each Premium Due Date thereafter;
- b) geographic location;
- c) class; and
- d) gender.]

As used in this Policy, Covered Person means a Retiree [or Dependent] who is covered under this Policy.

The premiums stated in this section are for [monthly] periods of coverage. If a premium becomes due for a different period of time, it will be determined pro rata.

Individual Plan Benefit [Monthly] Premiums

<u>[Age of Covered Person]</u>	<u>Premium</u>
65 – 69	
70 – 74	
75 – 79	
80 – 84	
85 and over]

Policy Premium: The premium for this Policy is the sum of Individual Premiums for Covered Persons.

Policy Premium Due Dates: This Policy Premium is payable on:

- a) [the Policy Effective Date; and
- b) the 1st day of each [month] thereafter, with respect to Covered Persons whose premium becomes due on such date.]

[Each Policy Premium is due on or in advance of the date it becomes payable. This Policy terminates on the last day of the period for which premium is paid, subject to the Policyholder Grace Period Provision.]

Policy Premium Payment: The Policy Premiums are to be paid to Us by the Policyholder. However, they may be paid to Us by any other person according to a mutual agreement among the other person, the Policyholder and Us.

Change of Policy Premiums: We have the right on [any Premium Due Date] to change the rate at which future premiums will be calculated. This includes the right to change premium rates for a benefit that applies to all individuals of the same [class, Age, gender and geographic location.]

Rates may be changed based on:

- a) [changes in Medicare;
- b) the claims experience of this Policy;
- c) state or federal legislation affecting health insurance coverage with which this Policy must comply; or
- d) the experience of all groups to which We issue group retiree medical coverage providing similar benefits.]

We will give the Policyholder advance written notice of any change in premium rates at least [30 days] prior to the Premium Due Date on which the change is to become effective.

Policyholder Grace Period Provision: A grace period of [31 days] is allowed for payment of each Policy Premium due after the first, unless the Policy is cancelled on or before such due date. This Policy will continue in force during the grace period. The Policyholder is liable to Us for the payment of premium accruing for the period this Policy continues in force.

[PARTICIPATING ENTITIES]

The Policyholder means the company named on the face page of the Policy.

Participating [Entity] means a company named below.

The Policyholder or We [by written request] may add to, or delete from, the list of Participating [Entities] at any time. Any change We agree to will become effective on a date which is mutually agreeable to the Policyholder and Us.

[Name of Participating [Entity]]	Effective Date	Account Number
DEF Company	April 1, 2008	AGP-XXXX

The Policyholder will act for and on behalf of each Participating [Entity] in all matters concerning this Policy.

Every:

- a) act of the Policyholder;
- b) agreement made between the Policyholder and Us;
- c) notice given by Us to, or to Us by, the Policyholder;

is binding on each Participating [Entity].

Each reference in this Policy to a relationship between the Policyholder and its Eligible Persons includes the same relationship between each Participating [Entity] and its Eligible Persons, except where this Policy describes specific differences.

Individual Effective Date: A person associated with a Participating [Entity] will not:

- a) become an Eligible Person before the [Entity] qualifies; or
- b) continue as an Eligible Person after the [Entity] ceases to qualify;

as a Participating [Entity].

Premiums: A Participating [Entity's] premiums will be calculated based on:

- a) the coverage requested; and
- b) the data given to Us by the Participating [Entity].

Data Given by Participating [Entity]: The Participating [Entity], with Our approval, may keep the important insurance records on all associated Covered Persons.

The insurance records of the Policyholder and/or the Participating [Entity] will be open for Our inspection at any reasonable time.

The Participating [Entity] will give Us:

- a) [the names of all persons initially eligible;
- b) the names of all new persons who become eligible;
- c) the names of all Covered Persons whose insurance is terminated;
- d) the names of all persons whose benefit is to change; and
- e) any data necessary to calculate premiums.]

The Participating [Entity's] failure to:

- a) [give Us the name of any Covered Person will not invalidate such person's insurance;
- b) report a Covered Person's termination of insurance will not continue coverage after the date of termination.]

Upon termination of coverage, any unearned premium will be determined on a pro rata basis. Upon request, We will promptly return any unearned premium paid.

Participating [Entity] Termination Date: An entity will cease to be a Participating [Entity] on the first to occur of:

- a) [the date the Participating [Entity] ceases to be associated with the Policyholder;
- b) the date requested by the Participating [Entity] but not prior to Our receipt of the Request;
- c) the termination date of the Policy; or
- d) the Premium Due Date on which a required premium is not paid by the Participating [Entity].]

CONTRACT PROVISIONS

Entire Contract: The entire contract between the Policyholder and Us consists of this Policy, the Policyholder's application form for the Policy, and any other forms made a part of this Policy.

All statements made by the Policyholder or the Covered Person will be deemed representations and not warranties. No statement made to effect this insurance will:

- a) void the insurance; or
- b) reduce benefits unless it is in writing and signed by the Policyholder or the Covered Person.

Changes: We reserve the right to make changes in this Policy. We will give the Policyholder [30 days] advance written notice of any change.

No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, approved by one of Our officers and made a part of this Policy.

Time Periods: All periods begin and end at [12:01 A.M., Standard Time] at the place where this Policy is delivered.

Certificates: We will give individual Certificates of Plan Benefits to:

- a) the Policyholder; or
 - b) any other person according to a mutual agreement among the other person, the Policyholder and Us;
- for delivery to each person covered under this Policy with respect to himself [and any Dependents].

The Certificates will contain all the provisions of the Policy that are important to each Covered Person.

[30 Day] Right to Examine Certificate: Each person receiving a Certificate has a [30 day] right to examine his or her Certificate. If such person is not satisfied, he or she may return it to Us within [30 days] of the date of its delivery. In that event, We will consider it void from the Certificate effective date, and any premium paid will be refunded to either the Policyholder or such person. Any claims paid will be deducted from the refund.

[Data Furnished by Policyholder: The Policyholder, or any other person designated by the Policyholder, may keep the important insurance records on all Covered Persons. The Policyholder or its designee must give Us information, when and in the manner We ask, to administer the insurance provided by this Policy.

The Policyholder or designee will, upon Our request, give Us:

- a) [the names of all persons initially eligible;
- b) the names of all new persons who become eligible;
- c) the names of all Covered Persons whose insurance is terminated;
- d) the names of all persons whose benefit is to change; and
- e) any data necessary to calculate premiums.]

The Policyholder's failure to:

- a) [give Us the name of any Covered Person will not invalidate such person's insurance; or
- b) report a Covered Person's termination of insurance will not continue coverage after the date of termination.]

The Policyholder's insurance records will be open for Our inspection at any reasonable time.]

CONTRACT PROVISIONS (Continued)

Clerical Error: Clerical error, whether by the Policyholder, a third party administrator or Us, in keeping the records having to do with this Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. Such clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by this Policy.

When a clerical error is found, premiums and benefits will be adjusted based on the true facts and this Policy.

[Misstatement of Age: If the Age of a Covered Person has been incorrectly stated, the premium rates will be adjusted to the correct Age of the person. If the change in Age affects the Covered Person's benefits, the benefits will be corrected accordingly and the premium adjustment will take this correction into account.]

Policy Cancellation: Notice of Policy cancellation may be provided at any time by written notice sent by Us to the Policyholder or by the Policyholder to Us. If We cancel, We will deliver the notice to the Policyholder at its last address shown in Our records.

If We cancel, it becomes effective on the later of:

- a) the date stated in the notice; or
- b) the [31st day] after We mail or deliver the notice (60 days in New Jersey).

If the Policyholder cancels, it becomes effective on the later of:

- a) the date We receive the notice;
- b) the date stated in the notice; or
- c) the [31st day] after the notice is delivered.

If cancellation occurs:

- a) We will promptly return any unearned premium paid; or
- b) the Policyholder will promptly pay any earned premium that has not been paid.

Any earned or unearned premium will be determined on a pro rata basis.

Cancellation will be without prejudice to any claim that originated prior to the effective date of the cancellation.

Not in Lieu of Worker's Compensation: This Policy does not satisfy any requirement for worker's compensation insurance.

Conformity with Law: If any provision of this Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law.

INCORPORATION PROVISION

The Certificate(s) of Plan Benefits, Schedule(s) of Benefits, [and Riders] listed below are attached to, incorporated in and made a part of this Policy.

<u>[Form]</u>	<u>Applicable to:</u>	<u>Effective Date of Incorporation</u>
Form GBD-1570 CRT A.1	All Eligible Persons	[Date]
Form GBD-1570 SCHED	All Eligible Persons	[Date]]

The provisions listed below are shown in the Certificate(s) of Plan Benefits, and are hereby incorporated into and made a part of this Policy.

[Definitions
Eligibility and Enrollment
Period of Coverage
[Conversion Privilege]
Basic Plan Benefits
Additional Plan Benefits
Eligibility for Payment of Benefits
[Extension of Benefits]
[Pre-existing Condition Limitation]
General Exclusions
Claim Provisions
[State Mandates and Exceptions Provisions]
Riders (if any)]

The Schedule of Benefits will control the:

- a) benefit amounts and maximum limits;
 - b) Eligible Persons Description and coverage effective date(s); and
 - c) other schedule amounts and limits;
- which apply to the Retirees of the Policyholder.



**THE HARTFORD GROUP RETIREE INSURANCE PLAN ®
CERTIFICATE OF PLAN BENEFITS**

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Simsbury, Connecticut
(A stock insurance company)

[Policyholder: ABC Policyholder]
[Participating Entity]
[Policy Number: XXX-XXXXXXX]
[Policy Effective Date: DATE]

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Richard G. Costello, Secretary

Thomas M. Marra, President

READ YOUR CERTIFICATE CAREFULLY

You have a [30] day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within [30] days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial [30] day period will be deducted from the refund.

Notice to buyer: The Policy may not cover all of the costs associated with medical care Incurred by you during the period of coverage. You are advised to review carefully all Policy limitations contained in this certificate.

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

YOUR SCHEDULE OF BENEFITS SHOWS THE BENEFITS FOR WHICH YOU [AND/ OR YOUR DEPENDENTS] ARE COVERED. THIS CERTIFICATE MAY DESCRIBE BENEFITS NOT INCLUDED IN YOUR PARTICULAR PLAN. PLEASE CHECK YOUR SCHEDULE OF BENEFITS TO DETERMINE SPECIFIC COVERAGE UNDER THE POLICY.

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Certificate Face Page
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[Conversion Privilege]
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Additional Plan Benefits
Eligibility for Payment of Benefits
[Extension of Benefits]
[Pre-existing Condition Limitation]
General Exclusions
Claim Provisions]
[State Mandates and Exceptions Provisions]

DEFINITIONS

Not all definitions may be applicable to Your coverage under The Policy. Please check the Schedule of Benefits.

[Age]	means Your [and Your Dependent's] attained age on any Premium Due Date.]
GBD-1570 C01	
Benefit Period	means the period that begins the day You [or Your Dependent] are admitted into a Hospital [or Skilled Nursing Facility]. The benefit period ends when You [or Your Dependent] haven't received any inpatient Hospital care [or Skilled Nursing Facility care] for [60] days in a row. If You [or Your Dependent] go to a Hospital or a [Skilled Nursing Facility] after one benefit period has ended, a new benefit period begins. You [or Your Dependent] must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods, although inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.
GBD-1570 C02	
Calendar Year	means a period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.
GBD-1570 C03	
Calendar Year Deductible	means the amount of eligible expenses that You [and Your Dependent] must [each] Incur before any benefits are paid by Us during a Calendar Year. [Expenses Incurred to satisfy the Medicare Part [A] Deductible and Coinsurance do [not] apply to the Calendar Year Deductible.] The Calendar Year Deductible is shown in the Schedule of Benefits.
GBD-1570 C04	
Coinsurance	means the amount You [or Your Dependent] may be required to pay for certain expenses [after You [or Your Dependent] Incur Your [or Your Dependent's] Calendar Year Deductible.]
GBD-1570 C05	
Confined, Confines or Confinement	means being an inpatient in: a) a Hospital; [or] b) [a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any]; [or] c) [Hospice Care with respect to Hospice Care coverage, if any]; due to Sickness or Injury, for which a room and board charge is made.
GBD-1570 C06	

DEFINITIONS (Continued)

[Dependent Child(ren)]	<p>means :</p> <ul style="list-style-type: none"> a) Your unmarried child, stepchild, legally adopted child; or b) any other child related to You by blood or marriage [or domestic partnership]: <ul style="list-style-type: none"> 1) [who lives with You in a regular parent-child relationship; and/or] 2) [for whom You have legal guardianship; and/or] 3) [who You claimed as a dependent on Your last filed federal income tax return;] <p>provided such child is primarily dependent upon You for financial support and maintenance [and is entitled to Medicare by reason of disability].]</p>
GBD-1570 C08	

[Dependent Parent(s)]	<p>means Your [or Your Spouse's] parent, provided such parent is primarily dependent upon You for financial support and maintenance [and is entitled to Medicare by reason of Age].]</p>
GBD-1570 C09	

[Dependents]	<p>means [Your Spouse and Your Dependent Child(ren) and Your Dependent Parents]. A Dependent must be a citizen or legal resident of the United States [or one of its territories or protectorates].]</p>
GBD-1570 C10	

[Employer]	<p>means [the Policyholder].</p>
GBD-1570 C11	

[Hospice Care]	<p>means Medicare-approved medical and support services needed to manage the symptoms and relieve the pain of a terminal illness. The services must be provided through a Medicare-approved Hospice Care Program. Hospice Care includes but is not limited to:</p> <ul style="list-style-type: none"> a) [nursing care, therapies, medical supplies and appliances]; b) short-term inpatient respite care; and c) Physician, home health aide and counseling services.]
GBD-1570 C12	

[Hospital]	<p>[means an institution which:</p> <ul style="list-style-type: none"> a) is approved by Medicare and has agreed to participate in Medicare; b) operates pursuant to law; c) primarily and continuously provides medical care and treatment on an inpatient basis for sick and injured persons at the patient's expense; d) operates diagnostic and major surgical facilities either: <ul style="list-style-type: none"> 1) on its premises; or 2) in facilities available to the Hospital on a prearranged basis; 3) operates under the supervision of a staff of Physicians; and e) provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.). <p>Hospital does not mean any institution or part thereof that is used primarily as:</p> <ul style="list-style-type: none"> a) a nursing home, convalescent home, or Skilled Nursing Facility; b) a place for rest, custodial, educational or rehabilitative care; c) a place for the aged; or d) a place for alcoholism or drug addiction.]
GBD-1570 C13	

DEFINITIONS (Continued)

Incurred	means received, with respect to a particular treatment, service, or supply that gave rise to an expense.
GBD-1570 C14	
Injury	means bodily injury resulting: a) directly from accident; and b) independently of all other causes; [which occurs while You [or Your Dependent] are covered under The Policy]. Loss resulting from: a) Sickness or disease, except a pus-forming infection that occurs through an accidental wound; or b) medical or surgical treatment of a Sickness or disease; is not considered as resulting from Injury.
GBD-1570 C15	
[Limiting Charge	means the highest amount You [or your Dependent] can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.]
GBD-1570 C16	
Medical Care	means any professional or outpatient treatment, service, or supply that is covered by Medicare Part B.
GBD-1570 C17	
Medicare	means Title XVIII of the Social Security Act of 1965, as amended.
GBD-1570 C18	
Medicare Approved Amount	means the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or co-payment that You [or your Dependent] or Your health plan pays. It may be less than the actual amount a doctor or supplier charges.
GBD-1570 C19	
[Medicare Part A Deductible	means the amount that You [or Your Dependent] are required to pay under Medicare for the expenses Incurred at the beginning of a Benefit Period.]
GBD-1570 C20	
[Medicare Part B Deductible	means the initial amount that You [or Your Dependent] are required to pay under Medicare Part B each Calendar Year for Medicare eligible expenses.]
GBD-1570 C21	

DEFINITIONS (Continued)

Mental Illness	<p>[means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.</p> <p>For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:</p> <ul style="list-style-type: none"> a) Mental Retardation; b) Pervasive Developmental Disorders; c) Motor Skills Disorder; d) Substance-Related Disorders; e) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or f) Narcolepsy and Sleep Disorders related to a General Medical Condition.]
GBD-1570 C22	
Out-of-Pocket Expenses	<p>[means:</p> <ul style="list-style-type: none"> a) the portion of an expense that is covered under Medicare Part B but which is more than what Medicare considers reasonable, but does not exceed the Usual and Customary Charge; plus b) expenses used to satisfy the Medicare Part B Deductible to the extent the Medicare Part B Deductible is not covered under The Policy. <p>Out-of-Pocket Expenses do not include expenses that are excluded or limited under The Policy.]</p>
GBD-1570 C23	
Outpatient Surgical Procedure	<p>means a medically necessary surgical procedure performed by a Physician in the outpatient department of a hospital or ambulatory surgical center.</p>
GBD-1570 C24	
Physician	<p>means a person who is:</p> <ul style="list-style-type: none"> a) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize; b) licensed to practice in the jurisdiction where care is being given; c) practicing within the scope of that license; and d) not Related to You by blood or marriage [or domestic partnership].
GBD-1570 C25	

DEFINITIONS (Continued)

Prior Policy	means the [health insurance] carried by [the Employer] on the day before the [Policy] Effective Date.
GBD-1570 C26	
Related	means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.
GBD-1570 C27	
Request	means [written] request made on the forms We furnish for making the request.
GBD-1570 C28	
Retiree	<p>means a former employee of the Policyholder [or Participating [Entity]]:</p> <ul style="list-style-type: none"> a) [whose age plus years of services equals at least [X]; b) who has attained the Normal Retirement Age; c) who has completed at least [X] years of active full-time or part-time service with the Employer; d) who is participating in an Employer-sponsored pension plan; e) who retired from the Employer immediately after the last day as an active employee; f) who was on approved Waiver of Premium, immediately before retirement.] <p>Normal Retirement Age, as used above, shall mean the Age determined by the Policyholder [or Participating [Entity]] in their established guidelines.</p>
GBD-1570 C29	
Sickness	[means illness, disease or disorder of the body. However, sickness first manifested before Your [or Your Dependent's] coverage effective date will be subject to the Pre-existing Condition Limitation.]
GBD-1570 C30	
[Skilled Nursing Facility	<p>means an institution that:</p> <ul style="list-style-type: none"> a) [operates pursuant to law; b) in addition to room and board accommodations, is primarily engaged in providing skilled nursing care under the supervision of a Physician; c) provides continuous 24 hour a day nursing service by or under the supervision of a registered graduate nurse (R.N.); and d) maintains a daily medical record of each patient.] <p>Skilled Nursing Facility does not mean any institution or part thereof that is used mainly as a home or place:</p> <ul style="list-style-type: none"> a) [for the aged, or for rest, custodial or educational care; b) for alcoholism and drug addiction; c) for the treatment of Mental Illness.]]
GBD-1570 C31	

DEFINITIONS (Continued)

[Skilled Nursing Facility Expenses]	means Medicare Part A eligible expenses for services provided and billed by a Skilled Nursing Facility.]
GBD-1570 C32	

[Spouse]	means Your spouse who is not [legally separated or] divorced from You [,provided that the spouse is entitled to Medicare by reason of Age]. [Spouse will include Your domestic partner, provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy. You and Your partner will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit].]
GBD-1570 C34	

Totally Disabled	means that by Injury, Sickness or Mental Illness, You [or Your Dependent] are: a) continuously Confined in a Hospital or Skilled Nursing Facility; or b) prevented from engaging in the normal activities of a person of like age and gender in good health, as certified by Your [or Your Dependent's] Physician.
GBD-1570 C35	

[Trust]	means the Policyholder named on the face page of this certificate.]
GBD-1570 C36	

Usual and Customary Charge	means the prevailing charge made by most providers of a given service in the geographic area where the service is received. In no event will the Usual and Customary Charge exceed the actual amount charged.
GBD-1570 C37	

We, Us or Our	means the insurance company named on the face page of this certificate.
GBD-1570 C38	

You or Your	means the person to whom this certificate is issued.
GBD-1570 C39	

ELIGIBILITY AND ENROLLMENT

<p>Eligible Persons: <i>Who is eligible for coverage?</i></p>	<p>All persons in the class or classes shown in the Schedule of Benefits will be considered Eligible Persons.</p>
<p>GBD-1570 D01</p>	
<p>Eligibility for Coverage: <i>When will I become eligible?</i></p>	<p>You will become eligible for coverage on [the later of: a) the Policy Effective Date; and b) the date You become a member of an Eligible Class.]</p> <p>[If You and Your Spouse are both Retirees, only one of you may apply for retiree coverage, with the other person eligible for coverage as a Dependent. A [Dependent's] coverage under The Policy will not provide benefits that exceed the retiree's benefits under The Policy, however, this limitation does not apply in the event You are covered under Your Employer's employee health insurance policy.]</p>
<p>GBD-1570 D02</p>	
<p>[Eligibility for Dependent Coverage: <i>When will I become eligible for Dependent Coverage?</i></p>	<p>You will become eligible for Dependent coverage on [the later of: a) the date You become [insured] for retiree coverage; or b) the date You acquire Your first Dependent.]</p> <p>[No person can be insured as a Dependent of more than one retiree under The Policy.]]</p>
<p>GBD-1570 D03</p>	
<p>Eligibility Restriction: <i>Do any restrictions apply to how I [or my Dependents] can become eligible?</i></p>	<p>[In no event will a person be eligible for coverage under The Policy if he or she: a) is in engaged in active employment [or is the Dependent of a person engaged in active employment], and is [eligible to be] covered by an employer's health plan which is primary payor to Medicare; or b) is covered by Medicaid; or c) has other coverage in force that supplements Medicare or which provides coverage for his or her hospital or medical expense; or d) is not [eligible to be] covered by Medicare.]</p>
<p>GBD-1570 D04</p>	

ELIGIBILITY AND ENROLLMENT (Continued)

<p>Enrollment: <i>How do I enroll for coverage for myself [and my Dependents?]</i></p>	<p>[[If You are not required to contribute toward The Policy’s cost,] Your Employer will automatically enroll You.]</p> <p>[If You must contribute toward The Policy’s cost,] You must:</p> <ul style="list-style-type: none"> a) [complete and sign a group insurance enrollment form, satisfactory to Us, for Your coverage [and Your Dependent’s coverage]; and b) deliver it to Your Employer.] <p>[You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.]</p> <p>[In order to enroll for Your Dependent’s coverage, You must enroll for retiree coverage under The Policy or, as applicable, under Your Employer’s employee health insurance policy.]</p> <p>[If You do not enroll for Your coverage [and/or Your Dependent’s coverage] [within 31 days] after becoming eligible under The Policy, [or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll] You may only enroll for Your coverage [and/or Your Dependent’s coverage:]</p> <ul style="list-style-type: none"> a) [during an [Annual Enrollment Period] designated by the Policyholder; or b) within [31 days] of the date You have a Change in Family Status.]] <p>[The dates of the [Annual Enrollment Period] are shown in the Schedule of Benefits.]</p>
<p>GBD-1570 D05</p>	

<p>[Change in Family Status: <i>What constitutes a Change in Family Status?</i></p>	<p>A Change in Family Status occurs when:</p> <ul style="list-style-type: none"> a) [You get married or You execute a domestic partner affidavit; b) You and Your spouse divorce or terminate a domestic partnership; c) Your child is born or You adopt or become the legal guardian of a child; d) Your spouse or domestic partner dies; e) Your child is no longer financially dependent on You or dies; or f) Your spouse is no longer employed, which results in a loss of group insurance.]]
<p>GBD-1570 D06</p>	

**PERIOD OF COVERAGE
For Your Retiree Coverage**

[Effective Date: <i>When does my coverage start?</i>	If You are not required to contribute toward The Policy's cost, Your coverage will start on [the first day of the month on or next following] the date You become eligible. [If You attained Age 65 while covered under the Prior Policy, Your coverage will start on the date stated in the Prior Policy's Conversion provision.]]
GBD-1570 E01	

[Effective Date: <i>When does my coverage start?</i>	If You must contribute toward The Policy's cost, Your coverage will start on the latest to occur of: <ul style="list-style-type: none"> a) [the first day of the month on or next following the date You become eligible, if You enroll on or before that date; or b) the first day of the month on or next following the date We receive the Request, if it is received at any other time; or c) the first day of the month on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period;] subject to payment of the required premium. [If You attained Age 65 while covered by the Prior Policy, Your coverage will start on the date stated in the Prior Policy's Conversion provision, subject to payment of the required premium.]]
GBD-1570 E02	

[Changes in Coverage: <i>Can I change my benefit options?</i>	If You give Us a written Request for a change in coverage for which You are eligible [and pay the required premium], the change will become effective on [the first day of the month on or next following] the date We receive the Request. [If the Request is for an increase in coverage, the amount of the increase will be subject to the Pre-existing Condition Limitation provision.]]
GBD-1570 E03	

[Changes in Coverage: <i>Can I change my benefit option?</i>	You may change Your benefit option only: <ul style="list-style-type: none"> a) [during an Annual Enrollment Period; or] b) within [31 days] after a Change in Family Status.
<i>When will a requested change in benefit option take effect?</i>	[If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the first day of the month following the Annual Enrollment Period.] [If You enroll for a change in benefit option within [31 days] following a Change in Family Status, the change will take effect on the date You enroll for the change.] [Any such increase in coverage is subject to the Pre-existing Condition Limitation provision.]]
GBD-1570 E04	

PERIOD OF COVERAGE (Continued)
For Your Retiree Coverage (Continued)

<p>Changes in Coverage: <i>What happens if the Employer changes The Policy?</i></p>	<p>Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change [, subject to the Pre-existing Condition Limitation provision].</p>
<p>GBD-1570 E05</p>	
<p>Termination: <i>When will my coverage stop?</i></p>	<p>Your coverage will end on the earliest of:</p> <ul style="list-style-type: none"> a) [the date You cease to qualify within a class of persons eligible for coverage under The Policy;] b) [the date The Policy is cancelled;] c) [the date the Participating Entity ceases to participate; or] d) [the Premium Due Date any required premium contribution is not made, subject to the Individual Grace Period.] <p>[However, if You are eligible for coverage under The Policy because You are the widow or widower of [a/an active] employee of the Policyholder [or a Participating [Entity]], Your coverage will cease on the first day of the month on or next following the date You remarry or execute a domestic partner affidavit.]</p>
<p>GBD-1570 E06</p>	
<p>[Individual Grace Period: <i>What happens if I pay my premium late?</i></p>	<p>You will be allowed an Individual Grace Period of [31 days] from the Premium Due Date for payment of each premium due after the initial premium. Your insurance will be continued during the Individual Grace Period. If You [or Your Dependent] Incur a covered loss during the Individual Grace Period, You [or Your Dependent] will be liable to Us for payment of any premium accruing during the period We continued coverage in force under the provision.</p> <p>The Individual Grace Period will not continue coverage after any date on which coverage would end, as described in the Termination provision.]</p>
<p>GBD-1570 E07</p>	

PERIOD OF COVERAGE (Continued)
For Your Dependent Coverage

Dependent coverage is indicated in the Schedule of Benefits, if applicable. If such Schedule does not identify a Dependent, then he or she is not covered under The Policy.

[Dependent Effective Date: <i>When does Dependent coverage start?</i>	If You are not required to contribute toward The Policy's cost, coverage will start on [the first day of the month on or next following] the date You become eligible for Dependent coverage. [In no event will Dependent coverage become effective before You become [insured] under The Policy, or the Prior Policy.]]
GBD-1570 E08	

[Dependent Effective Date: <i>When does Dependent coverage start?</i>	If You must contribute toward The Policy's cost, coverage will start on the latest to occur of: a) [the first day of the month on or next following the date You become eligible for Dependent coverage, if You enroll on or before that date; or b) the first day of the month on or next following the date We receive the Request, if it is received at any other time; or c) the first day of the month on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period;] subject to payment of the required premium. [In no event will Dependent coverage become effective before You become [insured] under The Policy.]]
GBD-1570 E09	

[Changes in Coverage: <i>Can I change my Dependent benefit options?</i>	If You give Us a written Request for a change in coverage for which [Your Dependent(s) is/are] eligible and [pay the required premium], the change will become effective on [the first day of the month on or next following] the date We receive the Request. [If the Request is for an increase in coverage, the amount of the increase will be subject to the Pre-existing Condition Limitation provision.]]
GBD-1570 E10	

[Changes in Coverage: <i>Can I change my Dependent benefit options?</i>	You may change Your Dependent benefit options only: a) [during an Annual Enrollment Period; or] b) within [31 days] after a Change in Family Status.
<i>When will a requested change in Dependent benefit options take effect?</i>	[If You enroll for a change in Dependent benefit options during an Annual Enrollment Period, the change will take effect on the first day of the month following the Annual Enrollment Period.] [If You enroll for a change in Dependent benefit options within [31 days] following a Change in Family Status, the change will take effect on the date You enroll for the change.] [Any such increase in coverage is subject to the Pre-existing Condition Limitation provision.]]
GBD-1570 E11	

PERIOD OF COVERAGE (Continued)
For Your Dependent Coverage (Continued)

[Dependent Termination: <i>When does coverage for my Dependent end?</i>	Coverage for Your Dependent will end on the earliest to occur of: a) [the date Your coverage ends; b) the date the required premium is due but not paid; c) the date You are no longer eligible for Dependent coverage; d) the date We or the Employer terminate Dependent coverage; or e) the date the Dependent no longer satisfies the definition of Dependent;] [unless continued in accordance with one of the following Continuation provisions.]]
GBD-1570 E12	

[Dependent Termination: <i>When does coverage for my Dependent end?</i>	Coverage for Your Dependent ends on the earliest to occur of: a) [the date The Policy terminates; b) the date Your coverage ends; or c) the Premium Due Date on or next following the date: 1) the required premium is not paid, subject to the Individual Grace Period provision; 2) with respect to Your Spouse, he or she no longer meets the definition of Spouse; or 3) with respect to Your Dependent Child or Dependent Parent, he or she no longer meets the definition of Dependent Child or Dependent Parent;] [unless continued in accordance with one of the following Continuation provisions.] [However, if Dependent coverage would terminate because of Your death, coverage will continue until the Premium Due Date on or next following the date of Your death unless continued in accordance with the Divorced Spouse Continuation provision.]]
GBD-1570 E13	

[Dependent Continuation Provisions: <i>Can coverage for my Dependents be continued beyond the date it would otherwise terminate?</i>	Dependent coverage under The Policy may be continued, at Your Employer's option, after a date on which coverage would end as described in the Termination provision, provided Your Employer's plan of continuation applies to Dependents of all Retirees the same way. Coverage may not be continued under more than one of the following Continuation provisions. The amount of continued coverage applicable to Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage: a) is subject to any reductions in The Policy; b) is subject to payment of premium; c) may be continued up to the maximum time shown in the provisions; and d) terminates if: 1) [The Policy terminates; or] 2) [Your Employer ceases to be a Participating Entity.] In no event will the amount of coverage increase while coverage is continued in accordance with one of the following Continuation provisions. In all other respects, the terms of coverage for Your Dependents remain unchanged.]
GBD-1570 E14	

PERIOD OF COVERAGE (Continued)
For Your Dependent Coverage (Continued)

<p>[Divorced Spouse Continuation: <i>Can coverage for my Spouse be continued in the event of our Divorce?</i></p>	<p>If You and Your Spouse become Divorced while Your Spouse is covered under The Policy, Your Spouse may continue his or her coverage. We must receive Your Spouse's Request and the required premium to continue the coverage within [31 days] of the date Your Spouse's coverage terminates. Solely for the purpose of continuing the coverage under The Policy, the Spouse will be considered the insured person.</p> <p>However, Your Spouse's coverage will not continue after:</p> <ul style="list-style-type: none"> a) a date the coverage would normally end under the Termination provision of The Policy; or b) the Premium Due Date next following the date he or she remarries [or executes another domestic partner affidavit]. <p>[Divorce/Divorced means annulment, dissolution of marriage, legal separation, [or termination of a domestic partnership.]]</p>
GBD-1570 E15	

<p>[Surviving Dependent Continuation: <i>Can coverage for my Dependents be continued if I die?</i></p>	<p>If You die while [covered] under The Policy, coverage for Your Dependents that is in force on the date of Your death may be continued, until [the earliest of:</p> <ul style="list-style-type: none"> a) the date the coverage would otherwise have ended under the Dependent Termination provision; b) [the date Your Spouse remarries, [or executes another domestic partner affidavit];] c) [the date Your Spouse obtains coverage under another group plan; or] d) [5 years from the date of Your death.]] <p>[We] must receive Your Dependent(s) written Request and the required premium to continue the coverage within [31] days of the Premium Due Date next following the date of Your death.</p> <p>Solely for the purpose of continuing the coverage, Your Spouse will be considered the insured person.</p> <p>[Coverage continued under this provision will be contributory coverage and may not be increased.]]</p>
GBD-1570 E16	

[CONVERSION PRIVILEGE]

<p>[Conversion Right: <i>If my coverage under The Policy stops, do I have a right to conversion?</i></p>	<p>If You [or Your Dependent] cease to be insured under The Policy because The Policy is cancelled and not replaced by another group policy, then You [or Your Dependent] will have the right to request conversion coverage without giving medical evidence of insurability. Such coverage will be issued under another group policy.</p> <p>To convert coverage, You [or Your Dependent] must:</p> <ul style="list-style-type: none">a) give Us a request for the conversion coverage; andb) pay the initial premium; <p>within [31 days] after You [or Your Dependent] cease to be covered under The Policy.</p> <p>Coverage under the conversion policy will be effective on the date coverage under The Policy terminates.</p> <p>The conversion coverage will:</p> <ul style="list-style-type: none">a) have the provisions, limitations and exclusions of the form We are issuing for this purpose at the time of conversion;b) provide benefits that are similar to the benefits that were in force under The Policy; andc) base premiums on the rates in effect for new applicants of Your [or Your Dependent's] age, gender and geographical location at the time of conversion.]
GBD-1570 F01	

BASIC PLAN BENEFITS

The Schedule of Benefits indicates the benefits applicable to You [and Your Dependents] while covered under The Policy.

[HOSPITAL CONFINEMENT BENEFIT]

<p>[Hospital Confinement Benefit: <i>What benefits are payable for Confinement in a Hospital?</i></p>	<p>When You [or Your Dependent] [is/are] Confined in a Hospital, We will pay the benefits stated below. The Confinement must be a Medicare approved Confinement. You [or Your Dependent] must Incur expenses for the Confinement while covered under this benefit.</p> <p>1st to 60th Day of Hospital Confinement: For the first 60 Days of approved Confinement during a Benefit Period, Medicare pays all inpatient Hospital expenses Incurred, except for the Medicare Part A Deductible.</p> <p>If a benefit is indicated as payable for Hospital Confinement in the Schedule of Benefits, We will pay a percentage of the Medicare Part A Deductible [and for the specified period of time], as shown in such Schedule.</p> <p>61st to 90th Day of Hospital Confinement: From the 61st to 90th day of approved Confinement during a Benefit Period, Medicare pays all inpatient Hospital expenses Incurred, except a daily Coinsurance charge equal to 25% of the Medicare Part A Deductible.</p> <p>If a benefit is indicated as payable for Hospital Confinement in the Schedule of Benefits, We will pay a percentage of the Medicare Part A Coinsurance charge, as shown in such Schedule.</p> <p>91st to 150th Day of Hospital Confinement (Lifetime Reserve Period): Regular Medicare Hospital benefits end on the 90th day of Confinement during a Benefit Period. After the 90th day, Medicare grants a 60 day Lifetime Reserve Period. These 60 additional days can be used only once in a lifetime. Medicare allows a person the choice of using the days or saving them for the future. If he or she uses the days, Medicare pays all inpatient Hospital expenses Incurred during the Lifetime Reserve Period except a daily Coinsurance charge equal to 50% of the Medicare Part A Deductible.</p> <p>If a benefit is indicated as payable for Hospital Confinement in the Schedule of Benefits, We will pay a percentage of the Medicare Part A Coinsurance charge, as shown in such Schedule.]</p>
GBD-1570 G01	

BASIC PLAN BENEFITS (Continued)

[SKILLED NURSING FACILITY BENEFIT]

<p>[Skilled Nursing Facility Benefit: <i>What benefits are payable for Confinement in a Skilled Nursing Facility?</i></p>	<p>When You [or Your Dependent] [is/are] Confined in a Skilled Nursing Facility, We will pay the benefit stated below. The Confinement must be a Medicare Approved Confinement as defined below. You [or Your Dependent] must Incur expenses for the Confinement while covered under this benefit.</p> <p>For the first 20 days of Medicare Approved Confinement during a Benefit Period, Medicare Part A pays all Skilled Nursing Facility Expenses. The Policy provides no coverage under this benefit for such 20 days.</p> <p>21st to 100th Day of Skilled Nursing Facility Confinement: From the 21st to 100th day of Medicare Approved Confinement during a Benefit Period, Medicare Part A pays all Skilled Nursing Facility Expenses except a daily Coinsurance charge equal to 12 1/2% of the Medicare Part A Deductible.</p> <p>If Your Schedule of Benefits indicates coverage for this benefit, We will pay a percentage of the Medicare Part A Coinsurance charges that You [or Your Dependent] Incur for such days.</p> <p>Medicare Approved Confinement: Medicare only approves Skilled Nursing Facility Confinement that provides skilled, medically necessary care:</p> <ul style="list-style-type: none">a) at a level that satisfies Medicare standards; andb) commencing within 30 days of discharge from a Hospital Confinement of at least 3 consecutive days; andc) that is recommended by Your [or Your Dependent's] Physician.]
GBD-1570 G02	

BASIC PLAN BENEFITS (Continued)

[OUTPATIENT MEDICAL EXPENSE BENEFIT]

<p>[Outpatient Medical Expense Benefit: <i>What benefits are payable for medical expenses Incurred on an outpatient basis?</i></p>	<p>[Medicare Part B Deductible Portion: If coverage is indicated for the Medicare Part B Deductible, in the Schedule of Benefits, We will pay a percentage of the Medicare Part B Deductible, as shown in such Schedule.</p> <p>The portion of an expense that is more than Medicare considers reasonable:</p> <ul style="list-style-type: none"> a) is not a Medicare Part B eligible expense; b) is not covered by Medicare; and c) is not covered under this benefit. <p>The expenses must be Incurred by You [or Your Dependent] while covered under this benefit.]</p> <p>[Medical Care Coinsurance Portion: During a Calendar Year, after the Medicare Part B Deductible is satisfied, Medicare generally pays 80% of Medicare Part B eligible expenses. You [or Your Dependent] pay the remaining [20%] of the Medicare eligible expenses. If Your [or Your Dependent's] Schedule of Benefits indicates coverage for that portion of this benefit, We will pay a percentage, as shown in such Schedule, of the Coinsurance amount of Medicare Part B eligible expenses.]</p> <p>[The balance of the Medicare Part B eligible expenses not paid by Us or Medicare are payable by You [or Your Dependent]. These are Out-of-Pocket Expenses. When Your [or Your Dependent's] Out-of-Pocket Expenses equal the amount shown in the Schedule of Benefits, We will pay [100]% of the Medicare Part B Coinsurance amount for You [or Your Dependent].]</p> <p>[The portion of an expense that is more than Medicare considers reasonable:</p> <ul style="list-style-type: none"> a) is not a Medicare Part B eligible expense; b) is not covered by Medicare; and c) is not covered under this benefit. <p>The expenses must be Incurred by You [or Your Dependent] while covered under this benefit.]]</p>
<p>GBD-1570 G03</p>	

[OUT-OF-POCKET EXPENSE CARRYOVER BENEFIT]

<p>[Out-of-Pocket Expense Carryover Benefit: <i>Can credit be given for an Out-of-Pocket Expense Maximum, when similar Expenses are Incurred during the prior Calendar Year?</i></p>	<p>If:</p> <ul style="list-style-type: none"> a) You [or Your Dependent] become covered under The Policy during the last [3] months of a Calendar Year, and b) You [or Your Dependent] Incur Out-of-Pocket Expenses during the last [3] months of that Calendar Year; and c) those Expenses are applied to his or her Out-of-Pocket Expense Amount during that Calendar Year; <p>then Your [or Your Dependent's] Out-of-Pocket Expense Maximum for the next Calendar Year will be reduced by the amount of Expenses described in item b).</p> <p>The Out-of-Pocket Expense Maximum amount is:</p> <ul style="list-style-type: none"> a) stated in the Schedule of Benefits; and b) applies to You [and each of Your Dependents] each Calendar Year. <p>Only Out-of-Pocket Expenses can be used to satisfy the Out-of-Pocket Expense Maximum.]</p>
<p>GBD-1570 G04</p>	

ADDITIONAL PLAN BENEFITS

[EXTENDED HOSPITAL CONFINEMENT BENEFIT]

<p>[Extended Hospital Confinement Benefit: <i>Are benefits payable for an extended Confinement in a Hospital?</i></p>	<p>Beginning on the 151st day of Confinement during a Benefit Period, We will pay the percentage shown in the Schedule of Benefits, for Usual and Customary Charges for inpatient Hospital expenses Incurred for each day of Confinement during that Benefit Period. This benefit is subject to a lifetime maximum, per person, of [365] days of Confinement.]</p>
<p>GBD-1570 G05</p>	

[EXTENDED SKILLED NURSING FACILITY BENEFIT]

<p>[Extended Skilled Nursing Facility Benefit: <i>Are benefits payable for an extended Confinement in a Skilled Nursing Facility?</i></p>	<p>After the 100th day of Confinement in a Skilled Nursing Facility during a Benefit Period, Medicare benefits for Skilled Nursing Facility Confinements end.</p> <p>If Your [or Your Dependent's] Schedule of Benefits indicates coverage for this benefit, We pay the lesser of:</p> <ul style="list-style-type: none"> a) the daily amount stated in the Schedule of Benefits; or b) the room and board expense Incurred shown in such Schedule; <p>from the 101st to the [365th] day of Confinement.</p> <p>Payments under this benefit are limited to those days of Confinement that Medicare approves, or would have approved had Medicare benefits for the Confinement not been exhausted.]</p>
<p>GBD-1570 G06</p>	

ADDITIONAL PLAN BENEFITS (Continued)

[EXCESS OUTPATIENT MEDICAL EXPENSE BENEFIT]

<p>[Excess Outpatient Medical Expense Benefit: <i>Are benefits payable for additional medical expenses Incurred on an outpatient basis?</i></p>	<p>If Your [or Your Dependent's] Schedule of Benefits indicates coverage for this benefit, We will pay a percentage of the difference between:</p> <ul style="list-style-type: none">a) the actual Medicare Part B charge as billed; andb) the Medicare Approved Amount; <p>after the Medicare Part B Deductible is satisfied each Calendar Year. However, the amount of Our payment will not exceed the amount of any limit determined by state law, or the Limiting Charge established by Medicare. The expenses must be Incurred by You [or Your Dependent] while covered under this benefit.</p> <p>We will not pay this benefit if:</p> <ul style="list-style-type: none">a) the provider of the Medical Care accepts Medicare assignment; orb) the service or supply is not covered by Medicare Part B.]
<p>GBD-1570 G07</p>	

ADDITIONAL PLAN BENEFITS (Continued)

[FOREIGN TRAVEL EMERGENCY BENEFIT]

<p>[Foreign Travel Emergency Benefit: <i>Are benefits payable for medical expenses Incurred outside the United States?</i></p>	<p>We will pay a percentage of the expenses Incurred by You [or Your Dependent] for Foreign Travel Emergency Medical Treatment, if:</p> <ul style="list-style-type: none"> a) You [or Your Dependent] have satisfied the Calendar Year Deductible Amount; and b) the first expense was Incurred within the first [60 days] of travel Outside of the United States. <p>Payment under this benefit is limited to the Lifetime Maximum Benefit Amount.</p> <p>The percentage payable, Deductible Amount and Lifetime Maximum Benefit Amount are shown in the Schedule of Benefits if Your [or Your Dependent's] Schedule of Benefits indicates coverage for this benefit.</p> <p>This benefit does not cover Foreign Travel Emergency Medical Treatment if You [or Your Dependent]:</p> <ul style="list-style-type: none"> a) leave the United States primarily to seek Foreign Travel Emergency Medical Treatment for a Sickness or Injury; b) have no legal obligation to pay for such treatment; or c) receive such treatment during a Calendar Year in which You [or Your Dependent] travel or reside Outside of the United States for [6] consecutive months or longer. <p>This benefit does not cover Foreign Travel Emergency Medical Treatment if Medicare approves such treatment. In this case, other benefits shown in the Schedule of Benefits may apply.</p> <p>No other benefits shown in the Schedule of Benefits will be provided for any expense that is covered under this benefit.</p> <p>Foreign Travel Emergency Medical Treatment means any medically necessary Confinement, service, or supply needed immediately due to Injury or Sickness of sudden and unexpected onset while You [or Your Dependent] are Outside of the United States, provided that such medical treatment would, if received in the United States:</p> <ul style="list-style-type: none"> a) be considered reimbursable treatment under Medicare; and b) be considered in general use and of demonstrated value in the diagnosis and treatment of Sickness or Injury by Physicians within the United States; and c) not be considered in a research or experimental stage by Physicians within the United States. <p>[Outside of the United States means outside the territorial limits of:</p> <ul style="list-style-type: none"> a) the 50 United States and the District of Columbia; and b) Puerto Rico, the Virgin Islands, Guam and American Samoa.]]
<p>GBD-1570 G08</p>	

ADDITIONAL PLAN BENEFITS (Continued)

[PRIVATE DUTY NURSING BENEFIT]

<p>[Private Duty Nursing Benefit: <i>Are benefits payable for expenses Incurred for private duty nursing services?</i></p>	<p>If Your [or Your Dependent's] Schedule of Benefits indicates coverage for this benefit, We will pay a Private Duty Nursing Benefit for each 8 hour shift. In no event will We pay:</p> <ul style="list-style-type: none"> a) more than the actual amount charged for such shift; nor b) more than the Maximum Benefit Amount for such shift; nor c) for more than the Maximum Number of Shifts per Calendar Year. <p>The private duty nursing service must be provided to You [or Your Dependent] while You [or Your Dependent] are:</p> <ul style="list-style-type: none"> a) covered under this benefit; and b) Confined in a Hospital. <p>The private duty nursing services must be charged directly to You [or Your Dependent] by the Nurse and not charged by the Hospital.</p> <p>Nurse means:</p> <ul style="list-style-type: none"> a) [a Registered Graduate Nurse (R.N. or A.P.R.N.); or b) a Licensed Practical Nurse (L.P.N.); <p>who is not Related to You [or Your Dependent].]</p> <p>We will not pay for more than 3 shifts of private duty nursing services per day. A shift consists of at least 3 consecutive hours of nursing care. Shifts of more than 3 hours but less than 8 hours will be paid on a pro-rata basis.</p> <p>The Maximum Benefit Amount and the Maximum Number of Shifts are shown in the Schedule of Benefits.]</p>
<p>GBD-1570 G09</p>	

ADDITIONAL PLAN BENEFITS (Continued)

[AT-HOME RECOVERY BENEFIT]

<p>[At-Home Recovery Benefit: <i>Are benefits payable for services from a Care Provider at home?</i></p> <p><i>What requirements apply to At-Home Recovery Visits?</i></p> <p><i>Are certain types of visits excluded from this benefit?</i></p>	<p>If Your [or Your Dependent's] Physician certifies that You [or Your Dependent] require the services of a Care Provider for Home recovery from a Sickness, Injury or surgery for which a home care plan of treatment was approved by Medicare, and if Your [or Your Dependent's] Schedule of Benefits indicates coverage for this benefit, then We will pay the lesser of:</p> <ul style="list-style-type: none"> a) the expense Incurred; or b) the Maximum Amount per Visit; <p>for short term At-Home Recovery Visits, up to the Maximum Benefit Amount per Calendar Year.</p> <p>The At-Home Recovery Visits must be:</p> <ul style="list-style-type: none"> a) provided to a person while he or she is covered under this benefit; b) primarily to provide services which assist in Activities of Daily Living; c) provided on a visiting basis in Your [or Your Dependent's] Home; and d) provided while You [or Your Dependent] are receiving Medicare-approved home health care services, or within 8 weeks after the service date of the last Medicare home health care visit. <p>Your [or Your Dependent's] Physician must certify that the specific type and frequency of At-Home Recovery services are necessary because of a condition for which a home health care plan of treatment was approved by Medicare.</p> <p>This benefit will not pay for:</p> <ul style="list-style-type: none"> a) At-Home Recovery Visits that are paid for by Medicare or any other government program; b) At-Home Recovery Visits provided by family members, unpaid volunteers or providers who are not Care Providers; or c) more than the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment. <p>The Maximum Amount per Visit, the Maximum Visits per week, and the Maximum Benefit Amount are shown in the Schedule of Benefits.</p> <p>Activities of Daily Living means those daily activities necessary for a person to perform in order to function independently, including, but not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered and changing bandages or other dressings.</p> <p>At-Home Recovery Visit means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a Care Provider is considered one visit.</p> <p>Care Provider means a [duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.]</p> <p>Home means a place used by You [or Your Dependent] as a place of residence. It may be Your [or Your Dependent's] own dwelling, an apartment, a relative's home, a home for the aged or some other type of institution, provided that such a place would qualify as a residence for Home Health Care services covered by Medicare. A Hospital or Skilled Nursing Facility is not considered Your [or Your Dependent's] home.]</p>
<p>GBD-1570 G10</p>	

ADDITIONAL PLAN BENEFITS (Continued)

[PREVENTIVE MEDICAL CARE BENEFIT]

<p>[Preventive Medical Care Benefit: <i>Are benefits payable for preventive health services?</i></p>	<p>If Your [or Your Dependent's] Schedule of Benefits indicates coverage for this benefit, We will pay the actual charges up to the Medicare Approved Amount for expenses Incurred by Your [or Your Dependent] for:</p> <ul style="list-style-type: none"> a) an annual clinical preventive medical history and physical examination, that may include tests and services described in item b) below, and patient education to address preventive health care measures; and b) preventive screening tests or preventive services, the selection and frequency of which are determined to be medically appropriate by the attending physician. <p>This benefit may not include payment for any procedure covered under Medicare.</p> <p>The Maximum Benefit Amount is shown in the Schedule of Benefits.]</p>
<p>GBD 1570 G11</p>	

CANCER SCREENING BENEFIT

<p>Cancer Screening Benefit: <i>Are benefits payable for screening services?</i></p>	<p>We will pay the Usual and Customary Charges Incurred by You [or Your Dependent] for any of the following tests, provided the test is not covered under Medicare:</p> <ul style="list-style-type: none"> a) one mammography screening each Calendar Year ordered by a Physician; b) one cervical cancer screening each Calendar Year, or more frequently if certified by a Physician that such screening is medically necessary; and c) one prostate screening each Calendar Year for the early detection of prostate cancer for men over 50 years of age. The screening may be performed by any qualified medical professional, including a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner or physician assistant. The screening must include one or more of: a prostate-specific antigen (PSA) blood test, and a digital rectal examination.
<p>GBD-1570 G12</p>	

ADDITIONAL PLAN BENEFITS (Continued)

[HOSPICE CARE BENEFIT]

<p>[Hospice Care Benefit: <i>Are benefits payable for hospice care services?</i></p>	<p>Under Medicare, a terminally ill person may elect to receive Hospice Care benefits instead of most regular Medicare Part A and Part B benefits. Then, Medicare pays all approved Hospice Care charges except coinsurance charges for inpatient respite care, drugs and biologicals.</p> <p>If You [or Your Dependent] elect to receive Hospice Care, We will pay the Medicare Part A Coinsurance charges that You [or Your Dependent] Incur.</p> <p>The Hospice Care must:</p> <ul style="list-style-type: none"> a) be approved by Medicare; and b) be received while covered under this benefit. <p>In the event payment under this benefit is due for an expense, no other benefits of The Policy will be provided for that expense.]</p>
<p>GBD-1570 G13</p>	

[BLOOD DEDUCTIBLE BENEFIT]

<p>[Blood Deductible Benefit: <i>Are benefits payable for blood products?</i></p>	<p>Medicare does not cover the first 3 pints of blood received each Calendar Year.</p> <p>We pay the expenses You [or Your Dependent] Incur for these first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations.]</p>
<p>GBD-1570 G14</p>	

[EXTENSION OF BENEFITS]

<p>[Extension of Benefits: <i>Can coverage be extended, beyond a date coverage would end per the Termination provision?</i></p>	<p>If You [or Your Dependent] are Totally Disabled on the date Your [or Your Dependent's] coverage terminates, we will extend Your [or Your Dependent's] coverage for expenses Incurred as the result of that disability, subject to all benefit provisions, exclusions and limitations of The Policy.</p> <p>For Medicare Part A Eligible Expenses: Coverage for expenses Incurred for a Benefit Period for Medicare Part A eligible expenses which is established prior to termination will be extended until the first to occur of:</p> <ul style="list-style-type: none"> a) the date You [or Your Dependent] are no longer Totally Disabled; or b) the date You [or Your Dependent] have not been Confined in a Hospital or Skilled Nursing Facility for a period of [60 consecutive days]; or c) the [365th] day after termination. <p>If Your [or Your Dependent's] coverage terminates while You [or Your Dependent] are receiving Hospice Care, the Hospice Care Benefit of The Policy will continue until the end of the Hospice Care benefit period, as defined by Medicare.</p> <p>[For Medicare Part B Eligible Expenses: Cancellation or non-renewal of this certificate will be without prejudice to a continuous loss that began while this certificate was in force. Any Extension of Benefits beyond the period during which this certificate was in force will be based on the continuous Total Disability of You [or Your Dependent]. Benefits will be limited to the duration of the certificate benefit period, if any, or payment of the maximum benefit amounts.]</p> <p>[For Medicare Part B Eligible Expenses: The Benefit Period for Medicare Part B eligible expenses extends until the end of the Calendar Year quarter following the month termination occurs, as shown below:</p> <table border="0" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;">Termination Month</th> <th style="text-align: center;">Extension Date</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">January, February, March</td> <td style="text-align: center;">June 30 of same year</td> </tr> <tr> <td style="text-align: center;">April, May, June</td> <td style="text-align: center;">September 30 of same year</td> </tr> <tr> <td style="text-align: center;">July, August, September</td> <td style="text-align: center;">December 31 of same year</td> </tr> <tr> <td style="text-align: center;">October, November, December</td> <td style="text-align: center;">March 31 of next year.]]</td> </tr> </tbody> </table>	Termination Month	Extension Date	January, February, March	June 30 of same year	April, May, June	September 30 of same year	July, August, September	December 31 of same year	October, November, December	March 31 of next year.]]
Termination Month	Extension Date										
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October, November, December	March 31 of next year.]]										
<p>GBD-1570 I01</p>											

[PRE-EXISTING CONDITION LIMITATION]

<p>[Pre-existing Condition Limitation: Are benefits limited for Pre-existing Conditions?</p>	<p>Conditions Prior to Effective Date of Coverage: We will not pay a benefit under The Policy for any expenses Incurred:</p> <ul style="list-style-type: none"> a) during the first [two years] of Your [or Your Dependent's] coverage; and which b) are the result of a Pre-existing Condition; <p>[unless the Injury or Sickness begins after You [or Your Dependent] have been free of Medical Care for that condition for a one year period ending on or after Your [or Your Dependent's] effective date of coverage.]</p> <p>Conditions Prior to Effective Date of Increase in Coverage: We will not pay an increased benefit under The Policy for any expenses Incurred:</p> <ul style="list-style-type: none"> a) during the first [two years] following the effective date of a change in Your [or Your Dependent's] coverage that increases Your [or Your Dependent's] benefits; and which b) are the result of a Pre-Existing Condition; <p>[unless the Injury or Sickness begins after You [or Your Dependent] have been free of Medical Care for that condition for a one year period ending on or after Your [or Your Dependent's] effective date of benefit increase.]</p> <p>[Change from a Related Policy: If Your [or Your Dependent's] coverage under The Policy is a conversion, without interruption, from coverage under the Policyholder's employee health insurance policy, then We will credit, toward satisfaction of this Pre-existing Condition Limitation provision, the period that You [or Your Dependent] were continuously covered by that policy immediately before such conversion. Any expenses Incurred which are payable under an Extension of Benefits provision of that policy will not be payable under The Policy.]</p> <p>[Replacement Coverage: If You [or Your Dependent]:</p> <ul style="list-style-type: none"> a) purchased coverage under The Policy in order to replace coverage under a prior retiree [group or individual] health insurance policy; and b) provide proof of coverage under that prior policy; <p>then We will credit, toward satisfaction of this Pre-existing Condition Limitation provision, the period that You [or Your Dependent] were continuously covered by that prior policy immediately before such replacement.]</p> <p>[However, if benefits under The Policy are greater than those provided by that prior policy, the [two year] Pre-existing Condition Limitation of this provision will apply only to such increase in benefits.]]</p>
<p>GBD-1570 J01</p>	

[PRE-EXISTING CONDITION LIMITATION (Continued)]

<p><i>[What is a Pre-existing Condition?]</i></p>	<p>Pre-existing Condition means any Injury or Sickness, diagnosed or undiagnosed, for which Medical Care is received by You [or Your Dependent]:</p> <ul style="list-style-type: none"> a) within the [12 month] period prior to the date Your [or Your Dependent's] coverage starts; or b) within the [12 month] period prior to the effective date of Your [or Your Dependent's] increase in coverage. <p>Medical Care is received when:</p> <ul style="list-style-type: none"> a) a Physician is consulted or provides medical advice; or b) Treatment is recommended or prescribed by, or received from, a Physician. <p>Treatment includes, but is not limited to:</p> <ul style="list-style-type: none"> a) medical examinations, tests, attendance or observations; b) medical services, supplies or equipment, including their prescription or use; and c) [prescribed drugs or medicines, including their prescription or use.] <p>All manifestations, symptoms, or findings which result:</p> <ul style="list-style-type: none"> a) from the same or related Injury or Sickness; or b) from any aggravations of the same or related Injury or Sickness; <p>are considered to be the same Injury or Sickness for the purpose of determining a Pre-Existing Condition.</p> <p>[This Pre-existing Condition Limitation does not apply to any increase in coverage due to a change in Medicare benefits.]]</p>
<p>GBD-1570 J02</p>	

GENERAL EXCLUSIONS

<p>Exclusions: <i>What is not covered under The Policy?</i></p>	<p>[The Policy does not cover:</p> <ul style="list-style-type: none"> a) any expense that is: <ul style="list-style-type: none"> 1) not a Medicare eligible expense; or 2) beyond the limits imposed by Medicare for such expense; or 3) excluded by name or specific description by Medicare, except as specifically provided under The Policy; or 4) Incurred for treatment for You [or Your Dependent] when payment is denied by Medicare because treatment was received from a non-participating provider; or b) any portion of a covered expense to the extent paid or payable by Medicare; or c) experimental or investigational treatment; or d) treatment not provided in accordance with general accepted professional medical standards; or e) any benefits payable under one Benefit of The Policy to the extent payable under another Benefit of The Policy; or f) covered expenses Incurred after coverage terminates except as stated in the Extension of Benefits provision; or g) expenses Incurred before coverage begins; or h) any expense that exceeds the Usual and Customary Charge; or i) elective surgery; or j) [telephone, e-mail, and internet connection, and telemedicine; or] k) orthognathic surgery; or l) surrogate parenting; or m) health services and associated expenses for sex transformation operations; or n) services and supplies paid for through a legal action or settlement; or o) any expense in connection with an injury or sickness which is due to war or act of war, whether declared or not; or p) Your [or Your Dependent's] commission, or attempted commission, of a felony; or q) unless otherwise covered in The Policy, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.] <p>[Certain services that are excluded according to this provision may, at Our discretion, be covered under The Policy, if the services are required as a part of an authorized, monitored care plan.]</p>
<p>GBD-1570 K01</p>	

CLAIM PROVISIONS

<p>Notice of Claim: <i>When should I notify the insurance company of a claim?</i></p>	<p>You must give Us[, or Our representative,] [written] notice of a claim within [30 days] after a covered loss begins. If You cannot give notice within that time, You must give it to Us as soon as reasonably possible. Such notice must include Your name, Your address, Your ID number and the Policy Number.</p>
GBD-1570 L01	
<p>Claim Forms: <i>Are special forms required to file a claim?</i></p>	<p>[Proof of loss is typically provided by telephone; however,] [If forms are required, they will be sent to You for providing proof of loss within [15 days] after We receive a notice of claim. If We do not send the forms within [15 days], You may submit any other [written] proof which fully describes the nature and extent of Your claim.]</p>
GBD-1570 L02	
<p>Sending Proof of Loss: <i>When must proof of loss be given?</i></p>	<p>[Written] proof of loss must be sent to Us within [90 days] after a covered loss begins. If proof is not given by the time it is due, it will not affect the claim if:</p> <ul style="list-style-type: none"> a) it was not possible to give proof within the required time; and b) proof is given as soon as possible; but c) not later than [1 year] after it is due, unless You are not legally competent. <p>[We may request proof of loss throughout Your claim period.] [In such cases, We must receive the proof of loss within [30 days] of the request.]</p>
GBD-1570 L03	
<p>Claim Payment: <i>When are benefit payments issued?</i></p>	<p>Periodic benefit payments will be made on a [monthly] basis after We receive the proof of loss satisfactory to Us, and will continue while the loss and Our liability continue. We will pay any other benefit due immediately after We receive the proof of loss satisfactory to Us.</p>
GBD-1570 L04	
<p>Claims to be Paid: <i>To whom will benefits for my claim be paid?</i></p>	<p>All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:</p> <ul style="list-style-type: none"> a) Your estate; b) a person who is a minor; or c) a person who is not legally competent; <p>then We may pay up to [\$1,000] to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.</p> <p>If You provide Us with a Written Release to do so, We may, at Our option, pay benefits directly to the institution or person rendering:</p> <ul style="list-style-type: none"> a) Hospital services; or b) nursing, medical, or surgical services; <p>unless You, or the person to whom the benefit is payable, requests otherwise in writing no later than the time the proof of loss is received by Us.</p> <p>Written Release means any written direction from You to pay benefits to the institution or person rendering the service. We will not require that the services be rendered by a particular institution or person.</p>
GBD-1570 L05	

CLAIM PROVISIONS (Continued)

<p>Claim Denial: <i>What notification will I receive if my claim is denied?</i></p>	<p>If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:</p> <ul style="list-style-type: none"> a) give the specific reason(s) for the denial; b) make specific reference to The Policy provisions on which the denial is based; c) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and d) provide an explanation of the review procedure.
<p>GBD-1570 L06</p>	
<p>Claim Appeal: <i>What recourse do I have if my claim is denied?</i></p>	<p>On any claim, You or Your representative may appeal to Us for a full and fair review. To do so You must request a review in writing within [180 days] of receipt of claim denial. You may:</p> <ul style="list-style-type: none"> a) request copies of all documents, records, and other information relevant to Your claim; and b) submit written comments, documents, records and other information relating to Your claim.
<p>GBD-1570 L07</p>	<p>We will respond to You in writing with Our final decision on the claim.</p>
<p>Assignment: <i>Can I assign benefits under The Policy?</i></p>	<p>You may assign the benefits of The Policy to the institution or person rendering service as described in the Claims to be Paid provision. You may not assign The Policy in any other way or to any other person.</p>
<p>GBD-1570 L08</p>	
<p>Legal Actions: <i>When can legal action be taken against the insurance company?</i></p>	<p>Legal action cannot be taken against Us:</p> <ul style="list-style-type: none"> a) sooner than [60 days] after the date proof of loss is given; or b) [3] years after the date [written] proof of loss is required to be given according to the terms of The Policy.
<p>GBD-1570 L09</p>	
<p>Fraud: <i>How does the insurance company deal with fraud?</i></p>	<p>Insurance fraud occurs when You [and/or the Employer] [and/or Your provider] provide Us with false information, or file a claim for benefits that contains any false, incomplete or misleading information, with the intent to injure, defraud or deceive Us. It is a crime if You [and/or the Employer] [and/or Your provider] commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You [and/or the Employer] [and/or Your provider] perpetrate insurance fraud.</p>
<p>GBD-1570 L10</p>	

SCHEDULE OF BENEFITS

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY, SIMSBURY, CT

THIS IS NOT A BILL

Policyholder:	Certificate Number:	Certificate Effective Date:
Policy Number:	Initial Premium Amount:	Schedule Effective Date:

Renewal Premium Information:		
Premium Period:	Premium Amount:	Premium Due Date:

Insured Person _____

Dependent(s) _____

Eligible Class(es) For Coverage:

[Class Description of Eligible Persons

- 1 All Retirees who are entitled to Medicare [by reason of Age].
- 2 All retirees who are covered under the Policyholder's [or the Participating [Entity's]] group health plan, and who are under age 65. Retirees in this class are not eligible for coverage under The Policy but may enroll their Eligible Dependents.
- 3 All widow/widowers of deceased spouses who were Retirees [or active employees] of the Policyholder [or the Participating [Entity]] and who are entitled to Medicare by [reason of Age].]

[Eligible Dependents: Class 1 and Class 2 Eligible Persons may apply for Dependent's Coverage.]

[Annual Enrollment Period: Month & Day through Month & Day/as determined by Your Employer on a yearly basis.]

Insured Person/Dependent Premium Due Dates: The initial premium for each person is due on the date he or she becomes covered under The Policy. Each premium after the initial premium is due at the end of the period for which his or her preceding premium was paid.

POLICY MAXIMUMS

Calendar Year Maximum Benefit: [None, \$50,000 - \$500,000 in \$10,000 increments]

Lifetime Maximum Benefit: [None, \$1,000,000 and \$2,000,000]

SCHEDULE OF BENEFITS

BASIC PLAN BENEFITS

[Basic Plan Calendar Year Deductible: [\$0 - \$3,000 in \$50 increments; could apply to Part A expenses only, Part B expenses only or Parts A and B expenses.]]

[Basic Plan Coinsurance: [0%-100% in 5% increments]]

[Basic Plan Out-Of-Pocket Expense Maximum: [Unlimited; \$500 - \$5000 in \$50 increments]]

<u>Benefit</u>	<u>Amount Payable</u>
[Hospital Confinement Benefit	
Day of Confinement	
1 st to 60 th Day	[Not covered]
	[[5% - 100%] of the Medicare Part A Deductible in 5% increments]
61 st to 90 th Day	[Not covered]
	[[5% - 100% in 5% increments] of the Medicare Part A Coinsurance charge per day]
91 st – 150 th Days (Lifetime Reserve Period)	[Not covered]
	[[5% - 100% in 5% increments] of the Medicare Part A Coinsurance charge per day]]
[Skilled Nursing Facility Benefit	
Day of Confinement	
1 st to 20 th Day	[Not Covered]
21 st to 100 th Day	[Not Covered]
	[[5% - 100% in 5% increments] of the Medicare Part A Coinsurance charge per day]]
[Outpatient Medical Expense Benefit	
[Medicare Part B Deductible Portion	[Not Covered]
	[[5 % - 100% in 5 % increments] of the Medicare Part B Deductible]
[Medical Care Coinsurance Portion (20% Medicare Part B Eligible Expenses)	[Not Covered]
	[[5 % - 100% in 5% increments] of the Medicare Part B 20% Coinsurance]]]
[Out-of-Pocket Expense Carryover Benefit	
	[Not Covered]
	[See Benefit]]

SCHEDULE OF BENEFITS

[ADDITIONAL PLAN BENEFITS

[The Basic Plan Calendar Year Deductible, Basic Plan Coinsurance, and Basic Plan Out-Of-Pocket Expense Maximum amounts do NOT apply to Additional Plan Benefits.]

<u>Benefit</u>	<u>Amount Payable</u>
[Extended Hospital Confinement Benefit	[Not covered] [5% - 100% in 5% increments] of Hospital Expenses Incurred for each day of Confinement for up to an additional 365 days of Confinement per lifetime]
[Extended Skilled Nursing Facility Benefit	[Not covered] [Room and Board Charges of [\$100 - \$500] a day in [\$100] increments]]
[Excess Outpatient Medical Expense Benefit	[Not covered] [80%, 90%,100%] of the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge.]]
[Foreign Travel Emergency Benefit	[Not covered] [[5%-100% in 5% increments] of the Foreign Travel Emergency Medical Treatment Expense Deductible Amount: [\$0- \$5,000 in \$50 increments] Lifetime Maximum Benefit Amount: [\$5,000 - \$250,000, in increments of \$5,000]]]
[Private Duty Nursing Benefit	[Not covered] [Maximum Benefit Amount: [\$10-\$100 in \$5 increments] per [8] hour shift Maximum Number of Shifts: [30 – 100 in increments of 5 per Calendar Year]]]
[At-Home Recovery Benefit	[Not covered] [Maximum Amount per Visit: [\$40] Maximum Visits per week: [7] Maximum Benefit Amount: [\$1,600 per Calendar Year]]]
[Preventive Medical Care Benefit	[Not covered] [Maximum Benefit Amount: [\$120] per Calendar Year, except as otherwise covered herein]]
Cancer Screening Benefit	[See Benefit]
[Hospice Care Benefit	[Not covered] [See Benefit]]
[Blood Deductible Benefit	[Not covered] [First 3 pints of blood]]

]

STATE MANDATES AND EXCEPTIONS PROVISIONS

The Certificate of Plan Benefits is amended, as follows:



GROUP INSURANCE APPLICATION

Application is hereby made to Hartford Life and Accident Insurance Company ("HLA") on the basis of the information contained in this application, the group risk specifications, the enrollment data, and available experience data. The application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective. If this application is approved by HLA's Home Office, it will be attached to and made part of the Group Policy(ies). Insurance will become effective on the requested effective date shown below, unless HLA sends written notice of a different effective date. If this application is not approved by HLA's Home Office, no insurance is in effect at any time, and any deposit premium HLA has received will be returned.

Coverage being applied for:

The Hartford Group Retiree Insurance Plan® (GRIP)

Are there any companies that are subsidiaries or affiliates of the applicant, which are also to be insured? If yes, please furnish a listing, [giving the name, address, effective date of coverage, and number of employees] for each such company. ____ Yes ____ No

[Is the benefit plan, for which insurance is being requested, subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended? ____ Yes ____ No

If yes: Please identify the Plan Number: _____

Will you be requesting a Schedule A Form 5500? ____ Yes ____ No

If yes, when (date) will you be requesting it? _____]

Applicant: _____
Legal Name of Entity

Address: _____

Employer Tax Identification Number (EDI): _____

Policyholder Name to which the group contract will be issued to (if different then applicant name): _____

Requested Effective Date: _____

Employer's Contribution: [[%] of the cost of the premium] OR [[\$] towards the cost of the premium] for the:

Retiree only Retiree and Dependent(s)

Eligible Insured (please choose all that apply):

<u>Class</u>	<u>Description of Class</u>
--------------	-----------------------------

- | | |
|----|---|
| I | <input type="checkbox"/> Retirees only, of [Employer] who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over.) |
| II | <input type="checkbox"/> Retirees of [Employer] and their Eligible Dependents who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over). |

Eligible Dependents are as follows:

- Spouse
- Domestic Partner
- Parent
- Child

- | | |
|-----|---|
| III | <input type="checkbox"/> All Retirees of [Employer] under age 65 are not eligible for coverage under this policy, but they may enroll their Eligible Dependents who are entitled to Medicare benefits [by reason of age (i.e. 65 years of age and over)]. |
| IV | <input type="checkbox"/> All widow or widowers who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over) whose deceased spouse was [an active employee/retiree] of [Employer]. |

[Coverage is not available to persons under age 65 who are Medicare disabled.]

[Employer] defines an Eligible Retiree as: _____

GRIP Plan Design(s) & Rate(s)

[Available in all states except: XX]

OR

Applicant accepts the plan design(s) and rate(s) as presented in the Proposal dated [xx/xx/xxxx].

The first rate review and adjustment for the GRIP Plan will be on [xx/xx/xxxx].

RESPONSIBILITIES

Please complete any additional information that is being requested in the spaces that are provided. Any incomplete information could result in the delay of the policy effective date and/or the materials that are needed.

Billing

Type: [List Bill]
Mode: [Monthly]

Billing Performed by: [The Hartford's Approved Billing Administrator]

Bill sent to: _____
Primary Contact for Billing:
Name: _____

Address: _____

Phone Number: (____) _____ - _____ E-Mail Address: _____@_____

Claims

Claims Paid by: [The Hartford's Approved Claims Administrator]

Eligibility

Duties Performed by: [The Hartford's Approved Enrollment Administrator]

Verify Eligibility: _____
Provide Eligibility
to The Hartford: _____

Maintain Eligibility: _____
Primary Contact for Eligibility:
Name: _____

Address: _____

Phone Number: (____) _____ - _____ E-Mail Address: _____@_____

Enrollment

Duties Performed by: [The Hartford's Enrollment Administrator]

- Number of Plans Offered: One(1) Plan to Retiree & Spouses
- plans to Retiree & Spouses
- Retiree and Dependent may only have same plan
- Retiree and Dependent do not have to have the same plan.
- Dependent may have a plan greater then Retiree
- Dependent may only have a plan equal to or less than Retiree
- Other
- Above plan(s) initially offered to the Retiree & Dependent, but they have the option to:
- Upgrade to another plan after the initial enrollment
- Downgrade to another plan after the initial enrollment period.

- Type of Enrollment:
- Auto-enroll Retiree and Dependents
- Opt-out enroll for Retirees and Dependents
- True voluntary for Retirees and Dependents

RESPONSIBILITIES (continued)

Applicant agrees to the following:

The Minimum Participation required to put the policy in force is <X> lives;

The Hartford plan(s) may be the only Group plan(s) sponsored by the <Policyholder>;

The Hartford must review and approve all announcement letters and/or solicitation materials prior to their release.

Agent of Record: Name and Address: (Please print or Type): _____

Sub-Agent of Record: Name and Address: (Please print or Type): _____

For Applicant: _____

Legal Name of Entity

Signature

Date

Name and Title of Authorized Signer

POLICY RIDER

The Policy is amended as stated below. This rider forms a part of the Policy and does not vary, waive, or extend any of the terms, conditions, or provisions of the Policy, except as stated herein.

In consideration of the required additional premium, the following provision(s) are added to the Policy:

Rider: This rider, issued on [April 5, 2008], forms a part of Policy Number [AGP-XXXX] issued to [ABC Employer]. This rider becomes effective [on the later to occur of:

- a) the effective date of the Policy; or
- b) the first day of the month on or next following the date We accept the Policyholder's application and required premium.]

In all other respects, the Policy remains the same.

Signed for Hartford Life and Accident Insurance Company:

[



Richard G. Costello, *Secretary*



Thomas M. Marra, *President*

]

CERTIFICATE OF PLAN BENEFITS RIDER

Your Certificate of Plan Benefits is amended as stated below. This rider forms a part of Your Certificate and does not vary, waive, or extend any of the terms, conditions, or provisions of the Certificate, except as stated herein.

In consideration of the required additional premium, the following provision(s) are added to Your Certificate:

Rider: This rider, issued on [April 5, 2008], forms a part of Your Certificate of Plan Benefits, and to Policy Number [AGP-XXXX] issued to [ABC Employer], to which Your Certificate is attached. This rider becomes effective [on the later to occur of:

- a) the effective date of Your Certificate of Plan Benefits; or
- b) the first day of the month on or next following the date We accept any required premium.]

In all other respects, Your Certificate of Plan Benefits remains the same.

Signed for Hartford Life and Accident Insurance Company:

[



Richard G. Costello, *Secretary*



Thomas M. Marra, *President*

]

Page #	Module #	Description	Use
		POLICY OF INCORPORATION FORM GBD-1570 A.1 et al	
Form GBD-1570 A.1	n/a	Face page	
Form GBD-1570 B.1	n/a	Schedule - Premiums	
Form GBD-1570 C.1	n/a	Participating Entities	Optional Provision
Form GBD-1570 D.1	n/a	Contract Provisions	
Form GBD-1570 D.2	n/a	Contract Provisions (Continued)	
Form GBD-1570 E.1	n/a	Incorporation Provision	
		CERTIFICATE OF PLAN BENEFITS FORM GBD-1570 CRT A.1 et al	
Form GBD-1570 CRT A.1	n/a	Face page	
Form GBD-1570 CRT B.1	n/a	Table of Contents	
		Definitions	
Form GBD-1570 CRT C.1	GBD-1570 C01	Age	
	GBD-1570 C02	Benefit Period	
	GBD-1570 C03	Calendar Year	
	GBD-1570 C04	Calendar Year Deductible	
	GBD-1570 C05	Coinsurance	
	GBD-1570 C06	Confined, Confines or Confinement	
Form GBD-1570 CRT C.2	GBD-1570 C08	Dependent Child(ren)	Optional module
	GBD-1570 C09	Dependent Parent(s)	Optional module
	GBD-1570 C10	Dependents	Optional module
	GBD-1570 C11	Employer	
	GBD-1570 C12	Hospice Care	Optional module
	GBD-1570 C13	Hospital	
Form GBD-1570 CRT C.3	GBD-1570 C14	Incurred	
	GBD-1570 C15	Injury	
	GBD-1570 C16	Limiting Charge	Optional module
	GBD-1570 C17	Medical Care	
	GBD-1570 C18	Medicare	
	GBD-1570 C19	Medicare Approved Amount	
	GBD-1570 C20	Medicare Part A Deductible	Optional module
	GBD-1570 C21	Medicare Part B Deductible	Optional module
Form GBD-1570 CRT C.4	GBD-1570 C22	Mental Illness	
	GBD-1570 C23	Out-of-Pocket Expenses	
	GBD-1570 C24	Outpatient Surgical Procedure	
	GBD-1570 C25	Physician	
Form GBD-1570 CRT C.5	GBD-1570 C26	Prior Policy	
	GBD-1570 C27	Related	
	GBD-1570 C28	Request	
	GBD-1570 C29	Retiree	
	GBD-1570 C30	Sickness	
	GBD-1570 C31	Skilled Nursing Facility	Optional module
Form GBD-1570 CRT C.6	GBD-1570 C32	Skilled Nursing Facility Expenses	Optional module
	GBD-1570 C34	Spouse	Optional module
	GBD-1570 C35	Totally Disabled	
	GBD-1570 C36	Trust	Optional module
	GBD-1570 C37	Usual and Customary Charge	
	GBD-1570 C38	We, Us or Our	
	GBD-1570 C39	You or Your	
		Eligibility and Enrollment	
Form GBD-1570 CRT D.1	GBD-1570 D01	Eligible Persons: <i>Who is eligible for coverage?</i>	
	GBD-1570 D02	Eligibility for Coverage: <i>When will I become eligible?</i>	
	GBD-1570 D03	Eligibility for Dependent Coverage: <i>When will I become eligible for Dependent coverage?</i>	Optional module

	GBD-1570 D04	Eligibility Restriction: <i>Do any restrictions apply to how I [or my Dependents] can become eligible?</i>	
Form GBD-1570 CRT D.2	GBD-1570 D05	Enrollment: <i>How do I enroll for coverage for myself [and my Dependents]?</i>	
	GBD-1570 D06	Change in Family Status: <i>What constitutes a Change in Family Status?</i>	Optional module
		Period of Coverage	
Form GBD-1570 CRT E.1	GBD-1570 E01	Effective Date: <i>When does my coverage start?</i>	Optional module
	GBD-1570 E02	Effective Date: <i>When does my coverage start?</i>	Optional module
	GBD-1570 E03	Changes in Coverage: <i>Can I change my benefit options?</i>	Optional module
	GBD-1570 E04	Changes in Coverage: <i>Can I change my benefit options?</i>	Optional module
Form GBD-1570 CRT E.2	GBD-1570 E05	Changes in Coverage: <i>What happens if the Employer changes The Policy?</i>	
	GBD-1570 E06	Termination: <i>When will my coverage stop?</i>	
	GBD-1570 E07	Individual Grace Period: <i>What happens if I pay my premium late?</i>	Optional module
Form GBD-1570 CRT E.3	GBD-1570 E08	Dependent Effective Date: <i>When does Dependent coverage start?</i>	Optional module
	GBD-1570 E09	Dependent Effective Date: <i>When does Dependent coverage start?</i>	Optional module
	GBD-1570 E10	Changes in Coverage: <i>Can I change my Dependent benefit options?</i>	Optional module
	GBD-1570 E11	Changes in Coverage: <i>Can I change my Dependent benefit options?</i>	Optional module
Form GBD-1570 CRT E.4	GBD-1570 E12	Dependent Termination: <i>When does coverage for my Dependent end?</i>	Optional module
	GBD-1570 E13	Dependent Termination: <i>When does coverage for my Dependent end?</i>	Optional module
	GBD-1570 E14	Dependent Continuation Provisions: <i>Can coverage for my Dependents be continued beyond the date it would otherwise terminate?</i>	Optional module
Form GBD-1570 CRT E.5	GBD-1570 E15	Divorced Spouse Continuation: <i>Can coverage for my Spouse be continued in the event of our Divorce?</i>	Optional module
	GBD-1570 E16	Surviving Dependent Continuation: <i>Can coverage for my Dependents be continued if I die?</i>	Optional module
		Conversion Privilege	
Form GBD-1570 CRT F.1	GBD-1570 F01	Conversion Right: <i>If my coverage under The Policy stops, do I have a right to conversion?</i>	Optional module
		Basic Plan Benefits	
Form GBD-1570 CRT G.1	GBD-1570 G01	Hospital Confinement Benefit: <i>What benefits are payable for Confinement in a Hospital?</i>	Optional module
Form GBD-1570 CRT G.2	GBD-1570 G02	Skilled Nursing Facility Benefit: <i>What benefits are payable for Confinement in a Skilled Nursing Facility?</i>	Optional module
Form GBD-1570 CRT G.3	GBD-1570 G03	Outpatient Medical Expense Benefit: <i>What benefits are payable for medical expenses Incurred on an outpatient basis?</i>	Optional module
	GBD-1570 G04	Out-of-Pocket Expense Carryover Benefit: <i>Can credit be given for an Out-of-Pocket Expense Maximum, when similar Expenses are Incurred during the prior Calendar Year?</i>	Optional module
		Additional Plan Benefits	
Form GBD-1570 CRT G.4	GBD-1570 G05	Extended Hospital Confinement Benefit: <i>Are benefits payable for an extended Confinement in a Hospital?</i>	Optional module
	GBD-1570 G06	Extended Skilled Nursing Facility Benefit: <i>Are benefits payable for an extended Confinement in a Skilled Nursing Facility?</i>	Optional module
Form GBD-1570 CRT G.5	GBD-1570 G07	Extended Outpatient Medical Expense Benefit: <i>Are benefits payable for additional medical expenses Incurred on an outpatient basis?</i>	Optional module
Form GBD-1570 CRT G.6	GBD-1570 G08	Foreign Travel Emergency Benefit: <i>Are benefits payable for medical expenses Incurred outside the United States?</i>	Optional module

Form GBD-1570 CRT G.7	GBD-1570 G09	Private Duty Nursing Benefit: <i>Are benefits payable for expenses incurred for private duty nursing services?</i>	Optional module
Form GBD-1570 CRT G.8	GBD-1570 G10	At-Home Recovery Benefit: <i>Are benefits payable for services from a Care Provider at home?</i>	Optional module
Form GBD-1570 CRT G.9	GBD-1570 G11	Preventive Medical Care Benefit: <i>Are benefits payable for preventive health services?</i>	Optional module
	GBD-1570 G12	Cancer Screening Benefit: <i>Are benefits payable for screening services?</i>	
Form GBD-1570 CRT G.10	GBD-1570 G13	Hospice Care Benefit: <i>Are benefits payable for hospice care services?</i>	Optional module
	GBD-1570 G14	Blood Deductible Benefit: <i>Are benefits payable for blood products?</i>	Optional module
		Eligibility for Payment of Benefits	
Form GBD-1570 CRT H.1	GBD-1570 H01	Benefit Payments: <i>What general rules apply to Our payment of benefits?</i>	
		Extension of Benefits	
Form GBD-1570 CRT I.1	GBD-1570 I01	Extension of Benefits: <i>Can coverage be extended, beyond a date coverage would end per the Termination provision?</i>	Optional module
		Pre-existing Condition Limitation	
Form GBD-1570 CRT J.1	GBD-1570 J01	Pre-existing Condition Limitation: <i>Are benefits limited for Pre-existing Conditions?</i>	Optional module
Form GBD-1570 CRT J.2	GBD-1570 J02	<i>What is a Pre-existing Condition?</i>	Optional module
		General Exclusions	
Form GBD-1570 CRT K.1	GBD-1570 K01	Exclusions: <i>What is not covered under The Policy?</i>	
		Claim Provisions	
Form GBD-1570 CRT L.1	GBD-1570 L01	Notice of Claim: <i>When should I notify the insurance company of a claim?</i>	
	GBD-1570 L02	Claims Forms: <i>Are special forms required to file a claim?</i>	
	GBD-1570 L03	Sending Proof of Loss: <i>When must proof of loss be given?</i>	
	GBD-1570 L04	Claim Payment: <i>When are benefit payments issued?</i>	
	GBD-1570 L05	Claims to be Paid: <i>To whom will benefits for my claim be paid?</i>	
Form GBD-1570 CRT L.2	GBD-1570 L06	Claim Denial: <i>What notification will I receive if my claim is denied?</i>	
	GBD-1570 L07	Claim Appeal: <i>What recourse do I have if my claim is denied?</i>	
	GBD-1570 L08	Assignment: <i>Can I assign benefits under The Policy?</i>	
	GBD-1570 L09	Legal Actions: <i>When can legal action be taken against the insurance company?</i>	
	GBD-1570 L10	Fraud: <i>How does the insurance company deal with fraud?</i>	
		ADDITIONAL FORMS	
Form GBD-1570 SCHED	n/a	Schedule of Benefits	
Form GBD-1575	n/a	State Mandates and Exceptions Provisions	Use as needed
Form GBD-1580	n/a	Group Application Form	
Form GBD-1595	n/a	Policy Rider Form	Use as needed
Form GBD-1598	n/a	Certificate of Plan Benefits Rider Form	Use as needed

SERFF Tracking Number: HARL-125556846 State: Arkansas
Filing Company: Hartford Life and Accident Insurance Company State Tracking Number: 38462
Company Tracking Number: GBD 2008 GRIP
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: GCF_AR_HLA_2008_GRIP_GBD-1570 A.I
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: HARL-125556846 State: Arkansas
 Filing Company: Hartford Life and Accident Insurance Company State Tracking Number: 38462
 Company Tracking Number: GBD 2008 GRIP
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: GCF_AR_HLA_2008_GRIP_GBD-1570 A.1
 Project Name/Number: /

Supporting Document Schedules

Satisfied -Name:	Certification/Notice	Review Status:	Approved-Closed	03/24/2008
Comments:	The enclosed Policy of Incorporation and Certificate of Plan Benefits forms have been tested for readability, and achieve the Flesch readability scores shown in the enclosed Readability Certification.			
Attachment:	3-19-08 Readability (HLA).pdf			
Satisfied -Name:	Application	Review Status:	Approved-Closed	03/24/2008
Comments:				
Attachment:	3-19-08 Application, GBD-1580 (HLA).pdf			
Bypassed -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	03/24/2008
Bypass Reason:	N/A			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	03/24/2008
Bypass Reason:	N/A			
Comments:				
Satisfied -Name:	3-19-08 Filing Letter	Review Status:	Approved-Closed	03/24/2008
Comments:	We submit the subject forms for your review and approval, for general use in your state. These forms are new, and not intended to replace any previously approved forms.			
Attachment:	3-19-08 Filing Letter (HLA).pdf			

SERFF Tracking Number: HARL-125556846 State: Arkansas
Filing Company: Hartford Life and Accident Insurance Company State Tracking Number: 38462
Company Tracking Number: GBD 2008 GRIP
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: GCF_AR_HLA_2008_GRIP_GBD-1570 A.I
Project Name/Number: /

Satisfied -Name: 3-19-08 NAIC Transmittal **Review Status:** Approved-Closed 03/24/2008
Comments:
Attachment:
3-19-08 NAIC Transmittal (HLA).pdf

CERTIFICATION OF READABILITY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Certification of Readability for Policy of Incorporation form GBD-1570 A.1 et al., and Certificate of Plan Benefits form GBD-1570 CRT A.1 et al.

I hereby certify that the above named forms comply with the N.A.I.C. Model Policy Language Simplification Act. The forms have been tested by an acceptable method specified in the model law and the following Flesch scores were obtained:

Form GBD-1570 A.1 et al.:	52.1
Form GBD-1570 CRT A.1 et al.:	53.4

Unless we hear from you to the contrary, we will assume that this certification satisfies the certification requirements for compliance with any present or future readability law enacted by your state. We understand that this certification will not be valid to the extent that there is a material difference between the readability law of your state and the N.A.I.C. model.



Medina Jett
Vice President and Chief Compliance Officer

March 11, 2008

Date



GROUP INSURANCE APPLICATION

Application is hereby made to Hartford Life and Accident Insurance Company ("HLA") on the basis of the information contained in this application, the group risk specifications, the enrollment data, and available experience data. The application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective. If this application is approved by HLA's Home Office, it will be attached to and made part of the Group Policy(ies). Insurance will become effective on the requested effective date shown below, unless HLA sends written notice of a different effective date. If this application is not approved by HLA's Home Office, no insurance is in effect at any time, and any deposit premium HLA has received will be returned.

Coverage being applied for:

The Hartford Group Retiree Insurance Plan® (GRIP)

Are there any companies that are subsidiaries or affiliates of the applicant, which are also to be insured? If yes, please furnish a listing, [giving the name, address, effective date of coverage, and number of employees] for each such company. ____ Yes ____ No

[Is the benefit plan, for which insurance is being requested, subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended? ____ Yes ____ No

If yes: Please identify the Plan Number: _____

Will you be requesting a Schedule A Form 5500? ____ Yes ____ No

If yes, when (date) will you be requesting it? _____]

Applicant: _____
Legal Name of Entity

Address: _____

Employer Tax Identification Number (EDI): _____

Policyholder Name to which the group contract will be issued to (if different then applicant name): _____

Requested Effective Date: _____

Employer's Contribution: [[%] of the cost of the premium] OR [[\$] towards the cost of the premium] for the:

Retiree only Retiree and Dependent(s)

Eligible Insured (please choose all that apply):

<u>Class</u>	<u>Description of Class</u>
--------------	-----------------------------

- | | |
|----|---|
| I | <input type="checkbox"/> Retirees only, of [Employer] who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over.) |
| II | <input type="checkbox"/> Retirees of [Employer] and their Eligible Dependents who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over). |

Eligible Dependents are as follows:

- Spouse
- Domestic Partner
- Parent
- Child

- | | |
|-----|---|
| III | <input type="checkbox"/> All Retirees of [Employer] under age 65 are not eligible for coverage under this policy, but they may enroll their Eligible Dependents who are entitled to Medicare benefits [by reason of age (i.e. 65 years of age and over)]. |
| IV | <input type="checkbox"/> All widow or widowers who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over) whose deceased spouse was [an active employee/retiree] of [Employer]. |

[Coverage is not available to persons under age 65 who are Medicare disabled.]

[Employer] defines an Eligible Retiree as: _____

GRIP Plan Design(s) & Rate(s)

[Available in all states except: XX]

OR

Applicant accepts the plan design(s) and rate(s) as presented in the Proposal dated [xx/xx/xxxx].

The first rate review and adjustment for the GRIP Plan will be on [xx/xx/xxxx].

RESPONSIBILITIES

Please complete any additional information that is being requested in the spaces that are provided. Any incomplete information could result in the delay of the policy effective date and/or the materials that are needed.

Billing

Type: [List Bill]
Mode: [Monthly]

Billing Performed by: [The Hartford's Approved Billing Administrator]

Bill sent to: _____
Primary Contact for Billing:
Name: _____

Address: _____

Phone Number: (____) _____ - _____ E-Mail Address: _____@_____

Claims

Claims Paid by: [The Hartford's Approved Claims Administrator]

Eligibility

Duties Performed by: [The Hartford's Approved Enrollment Administrator]

Verify Eligibility: _____
Provide Eligibility
to The Hartford: _____

Maintain Eligibility: _____
Primary Contact for Eligibility:
Name: _____

Address: _____

Phone Number: (____) _____ - _____ E-Mail Address: _____@_____

Enrollment

Duties Performed by: [The Hartford's Enrollment Administrator]

- Number of Plans Offered: One(1) Plan to Retiree & Spouses
- plans to Retiree & Spouses
- Retiree and Dependent may only have same plan
- Retiree and Dependent do not have to have the same plan.
- Dependent may have a plan greater then Retiree
- Dependent may only have a plan equal to or less than Retiree
- Other
- Above plan(s) initially offered to the Retiree & Dependent, but they have the option to:
- Upgrade to another plan after the initial enrollment
- Downgrade to another plan after the initial enrollment period.

- Type of Enrollment:
- Auto-enroll Retiree and Dependents
- Opt-out enroll for Retirees and Dependents
- True voluntary for Retirees and Dependents

RESPONSIBILITIES (continued)

Applicant agrees to the following:

The Minimum Participation required to put the policy in force is <X> lives;

The Hartford plan(s) may be the only Group plan(s) sponsored by the <Policyholder>;

The Hartford must review and approve all announcement letters and/or solicitation materials prior to their release.

Agent of Record: Name and Address: (Please print or Type): _____

Sub-Agent of Record: Name and Address: (Please print or Type): _____

For Applicant: _____

Legal Name of Entity

Signature

Date

Name and Title of Authorized Signer

March 19, 2008

Arkansas Department of Insurance
1200 W. Third St.
Little Rock, Arkansas 72201-1904



Hartford Life and Accident Insurance Company
NAIC #: 70815 FEIN #: 06-0838648

Christopher Berning
Compliance Specialist
GBD Compliance

PLEASE NOTE: An identical filing was submitted for Hartford Life Insurance Company.

RE: THE HARTFORD GROUP RETIREE INSURANCE PLAN ®

Policy of Incorporation, Form GBD-1570 A.1 et al
Certificate of Plan Benefits, Form GBD-1570 CRT A.1 et al
Schedule of Benefits, Form GBD-1570 SCHED
State Mandates and Exceptions Provisions, Form GBD-1575
Group Application, Form GBD-1580
Policy Rider, Form GBD-1595
Certificate of Plan Benefits Rider, Form GBD-1598

Dear Sir or Madam:

We submit the subject forms for your review and approval, for general use in your state. These forms are new, and not intended to replace any previously approved forms. A listing of the forms is also enclosed for your convenience.

Our forms present a program of group retiree health insurance, and are intended for issue to single employer groups located in your state, as well as to multiple employer trust groups that are eligible.

This insurance program covers retirees and their dependents. This is not a "Medicare Supplement" program. While there is coordination with the operation of Medicare Parts A and B benefits – as described in Certificate form GBD-1570 CRT A.1 et al – it is limited. We are filing our program as "group health – other" rather than "general health" which could subject the program to state mandated health benefit provisions. The concept of our program is akin to an indemnity product and, additionally, features no individual underwriting of eligible persons.

Flesch Test. The enclosed Policy of Incorporation and Certificate of Plan Benefits forms have been tested for readability, and achieve the Flesch readability scores shown in the enclosed Readability Certification.

Variability. The variable material is set off by brackets to be variable so that it may be added to, deleted from or changed.

If you have any questions or comments, please don't hesitate to call me, collect, at 860-843-3641. If it would be more convenient to fax or email your comments, my fax number is 860-843-3608 and my email address is Christopher.Berning@hartfordlife.com.

Sincerely,

Christopher Berning

Hartford Life
200 Hopmeadow Street
Simsbury, Ct 06089

Hartford Life
Mailing Address
P.O. Box 2999
Hartford, CT 06104-2999

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas					
2.	Department Use Only						
	State Tracking ID						
3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Hartford Life and Accident Insurance Company 200 Hopmeadow Street Simsbury, CT 06089	CT	Life-Other	091	70815	06-0838648	
4.	Contact Name & Address	Telephone #	Fax #	E-mail Address			
	Chris Berning P. O. Box 2999 Hartford, CT 06104-2999	860-843-3641	860-843-3608	Christopher.Berning@HartfordLife.com			
5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____					
6.	Company Tracking Number	GBD-1570 A.1					
7.	<input checked="" type="checkbox"/> New Submission	<input type="checkbox"/> Resubmission	Previous file # _____				
8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input checked="" type="checkbox"/> Trust <input type="checkbox"/> Other: _____					
9.	Type of Insurance	H21 Health					
10.	Product Coding Matrix Filing Code	H21-000 Health - Other					
11.	Submitted Documents	<input checked="" type="checkbox"/> Forms <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input checked="" type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input checked="" type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> Rates <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum					

		<input type="checkbox"/> Other _____
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12.	Filing Submission Date		
13.	Filing Fee (If required)	Amount <u>\$50.00</u>	Check Date <u>EFT</u>
		Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Check Number <u>EFT</u>
14.	Date of Domiciliary Approval	March 7, 2008	

15.	Filing Description:		
		Please see our cover letter.	

16.	Certification (If required)		
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>			
Print Name <u>Christopher Berning</u>		Title <u>Compliance Specialist</u>	
Signature 		Date: <u>March 19, 2008</u>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		GBD-1570 A.1
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number Previous State Filing Number
	Description			
01	Policy of Incorporation	GBD-1570 A.1 et al	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Certificate of Plan Benefits	GBD-1570 CRT A.1 et al	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Schedule of Benefits	GBD-1570 SCHED	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04	State Mandates and Exceptions Provisions	GBD-1575	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05	Group Application Form	GBD-1580	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06	Policy Rider	GBD-1595	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07	Certificate of Plan Benefits Rider	GBD-1598	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

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18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number		N/A		
This filing corresponds to form filing company tracking number		N/A		
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

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